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INDEX.

VOL. LXXXII NEW SERIES. (VOL. CXXXIII OLD SERIES.)

JULY TO DECEMBER 1906.

CLINICAL LECTURES.

TITLES.

AUTHORS.

CORRESPONDENCE—FOREIGN

CORRESPONDENCE—HOME.

EDUCATIONAL SUMMARY.

LABORATORY NOTES.

LEADING ARTICLES.

NOTES AND COMMENTS.

NOTES ON CURRENT TOPICS.

OBITUARY.

OPERATING THEATRES.

ORIGINAL PAPERS.

TITLES.

AUTHORS.

OUT-PATIENTS' ROOM.

REVIEWS OF BOOKS AND LITERARY NOTES.

TRANSACTIONS OF SOCIETIES.

WEEKLY SUMMARY OF MEDICAL LITERATURE.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIII. WEDNESDAY, JULY 4, 1906. No. 1.

NOTES AND COMMENTS.

What is Whiskey?

No judgment has been given by the Newington Sessions on the appeal against the magistrate's decision upon the question as to what constitutes Scotch and Irish whiskey. The justices were equally divided upon the point, so that the original position is maintained. Unless the appellants decide to bring the matter before the Sessions for re-hearing, the law will be laid down that it is unlawful to sell patent still spirit, pure or blended, in place of Scotch or Irish whiskey made from the old-fashioned and, as we believe, the more wholesome pot still.

Hospitalism.

WRITING to the *Times*, a correspondent of June 24th has entered a vigorous protest against the pauperising influences of medical charity, or, as he calls it, "hospitalism." He insists upon the disastrous fact that two-thirds of the population of London are habitual recipients of medical relief from voluntary or State-aided institutions. He is confident that two-thirds of the persons who die in London (infants excepted) have been treated gratuitously for the illness of which they die. His figures are truly Gargantuan. Besides the 40,000 patients who occupy the beds of the metropolitan charities, there is a free daily attendance of over 20,000 persons in addition at Poor-law stations, while the Sunday Fund registers over six million attendances at institutions on its list. The writer of the letter asserts that "the out-patient and casualty departments of the London hospitals are a disgrace to any community."

Panem et Circenses.

HE then goes on to attack what he calls a new scheme for adding to the pauperisation of the people. The object of his caustic comments is the fund under H.R.H. Princess Christian to provide spectacles for elementary school children at wholesale prices or less. He points out that nickel steel spectacles can be fitted at 1s. 1d. to 1s. 9d. per pair, and at lower prices still with blue steel rims. His contention is that parents who can afford to spend £5 to £10 a year on drink should not need a special Royal Fund to enable them to pay two or three shillings for spectacles. Most medical men will probably agree more or less cordially with that proposition, as well as with the wider argument in favour of curtailing the indiscriminate charity of the hospitals. Free spectacles are bad for opticians, just as free medical advice is bad for the general practitioner. Still, we cannot fully agree with the writer as to the danger of "hospitalism" to the country. "The popular clamour for *panem et circenses*," he perorates "heralded the fall of Rome; our modern equivalent is free education, free medicine, free meals, free pensions, and now free spectacles."

Herbalists and Death Certificates.

ONE of the most striking facts about the modern charlatan is his brazen assurance. No better illustration of this quality could be given than the demand on behalf of the members of a certain herbalists' college at Southport to grant certificates of death. The "College" claims to be "a school of non-poisonous herbal medicine, vitalian and personal hygiene." Last year it was flouted by the refusal of the local Registrar of Births and Deaths to accept a death certificate signed by one of its collegiates. In response it has formed a "People's League of Medical Freedom," which has adopted as its war-cry the claim "That any herbal or other practitioner be able to give a death certificate equally with allopathically-trained practitioners, so long as those who employ them are satisfied." Their manifesto asserts that the inalienable right of every Englishman to choose his own doctor is being threatened by the medical profession, who "are seeking parliamentary aid to suppress everyone but themselves," and that the only alternative to this injustice will be "when sick, to suffer and die without anybody's help or aid." Why do not these zealous guardians of freedom usurp the lawyer's profession on the ground that every man has an absolute right to choose his own lawyer? The man in the street, however, is apt in nine cases out of ten to believe in his own powers as a physician, whereas he is in doubt when it comes to a point of law.

At Last.

AT length a member of that strange sect, the "Peculiar People," has been brought to book and properly punished. A carman, named James Cook, belonging to that eccentric faith, was last week found guilty of the manslaughter of his children, Dorothy May, aged six years and nine months, and Hilda, eighteen months, by neglecting to summon medical aid during sickness. Cook had been previously convicted for manslaughter under similar circumstances, but was discharged with a caution. This time he has been sent to prison for nine months, with hard labour. It is to be

hoped that this salutary sentence will afford Cook time to ponder over the responsibility accepted by other folk with regard to the care of their children in sickness, a duty that the "Peculiars" complaisantly shift on to the shoulders of Providence. Fatalism of this kind constitutes a species of moral insanity, and those who are under its influence should be dealt with as mentally irresponsible persons. Clearly it is the duty of the State to protect the lives of its subjects, and the question arises whether the Peculiar People should be allowed to keep children in their power.

The Christian Science Trial.

THE trial of Dr. Adcock at the Old Bailey last week for manslaughter has come to an eminently unsatisfactory conclusion. The jury disagreed, and the case stands over until the next session. Under these circumstances, we are compelled to refrain from comment upon the death of Major Whyte while under the care of the accused, who has embraced the tenets of a curious sect who call themselves "Christian Scientists." For our own part, we see little or no difference between culpable neglect in providing medical attention if practised by a wealthy Christian Scientist or a poverty-stricken Peculiar People. The latter are now punished for deaths arising from culpable neglect to procure medical aid. Both sects claim to have divine authority for the rejection of that particular kind of human help. Surely, both bodies should be equally accountable to the law for the result of their criminal foolishness. In the case of Dr. Adcock, the matter is complicated by the fact that he is possessed of medical training and experience. It is high time that the exact legal position and responsibilities of Christian Scientists were authoritatively settled in the Law Courts. Just before going to press we learn that the judge has formally stated to the prosecution that in his opinion there was not sufficient evidence to prove guilt. The prosecution, therefore, may be abandoned.

LEADING ARTICLE.

THE REDEMPTION OF THE INEBRIATE—THE DEGRADATION OF THE *TIMES*.

WE regret to note that another of the series of puffs of the "Keeley Institute," headed "The Redemption of the Inebriate," upon which we commented in a leading article on May 23rd, was published in the *Times* of Wednesday last. In our article we clearly showed how disgraceful and slanderous were the imputations upon our profession conveyed in the puffs, and we gave besides more than sufficient reasons why they ought never to have been admitted in such a form, bearing the endorsement of the leading journal. We have little doubt these advertisements, in spite of their high price, will prove exceedingly profitable to the "Keeley Institute," but we have no doubt at all that however much the *Times* may find itself in pocket over the transaction the gain will in the end be many times outweighed by the injury inflicted upon the reputation of the paper. Up to late years the *Times* has indisputably claimed in every respect the title of leading journal—leading not only among British newspapers, but among those of the whole world—and its superiority has nowhere been more conspicuously displayed than in its advertising columns. Puffs, even of a harmless kind, printed so as to lead the ingenuous reader to take them for editorials, have been until recently undiscoverable in its pages; and it is questionable whether in former years the Keeley puffs would have been accepted even in the form of ordinary advertisements. The *Times* has hitherto always acknowledged and acted upon the fact that there is little difficulty in recognising medical pretenders of any kind, and has given proof of its motives by refusing certain classes of advertisements which have always found a place in other newspapers. The *Times*, in its editorial utterances has especially pointed out and dwelt upon the fact that "the whole enormous system of quack advertisements is conducted on the lines of implied disparagement of doctors," and yet the managers, who can hardly disclaim acquaintance with our statements, are now not ashamed knowingly to publish a series of puffs of the character we have exposed. We repeat it will not pay them in any sense of the word. Medical readers—and they number many thousands in every civilised land—men of science, and men of the world, will be indignant and disgusted to find the fountain of journalistic honour thus befouled for the sake of filthy lucre. Those the gods wish to destroy they first make mad; and we do not doubt that the present amazing business methods of the *Times* if persevered in will end in the destruction of all those things its founders and earlier conductors set most value on. The degradation of the *Times* will surely lead to further degradation of all that is at present inferior in the world of journalism. All this must form a source of deep regret to everyone who realises how great a power for good the *Times* in the past has been, and how much mightier a power it could have in time become had the old methods been continued by which it was once conducted and by which its well-deserved fame was established.

THE annual dinner of the Fellows of the Royal College of Surgeons of England will take place tomorrow (Thursday) evening. Fellows intending to be present who have not yet communicated with the honorary secretaries of the dinner committee at the College are requested to do so at once in order to facilitate the necessary arrangements as to numbers.

MR. JOSHUA PEDLEY has promised to provide one-third of the sum of £1,400 still required for the rebuilding of the Tottenham and Edmonton Dispensary premises conditional upon the committee finding the other two-thirds.

THE death is announced of Signor Garcia, the inventor of the laryngoscope, and a famous teacher of singing, at the ripe age of 101. When he was about 70 he married for a second time, two daughters being issue of the marriage. He did not touch wine or spirits until he was ninety and was still giving lessons to pupils at 96.

NOTES ON CURRENT TOPICS.

Prevention of Infantile Mortality.

IT is some satisfaction that at length the public conscience has been a little roused on the subject of infant mortality. In season and out of season, medical men have drawn attention to the scandalous havoc wrought among young children by ignorance and carelessness, but up to the present they have been as a voice crying in the wilderness. It does not follow, moreover, that with the awakening of the public conscience there will be a corresponding improvement of the public health, since there is much reason to fear that unless great care be taken the remedies adopted may be all but as bad as the disease. Assuredly, no case requires more careful or prudent consideration. Well-meaning people—and the well-meaning are often more dangerous than the ill-disposed—recognising, for instance, that it is difficult to procure pure milk for infants, are sure to jump to the conclusion that all that is necessary is to supply good milk to every home, with instructions as to its preparation for infants. They forget, however, that cow's milk, however pure and fresh, is at best a poor substitute for the milk by a healthy mother. Again, a wholesale establishment of *crech* s for the children of working women has been urged, forgetting that *crèche* —useful as they are—may very easily be allowed to sap the parental responsibility, which is the foundation of family life. They may, too, encourage the too early return of a woman to work after her confinement. The only improvement we can hope for in the health of infants must be through the mothers, and without educated, careful, and healthy mothers we shall not have healthy children. Any plan, therefore, which ignores the condition of the mothers will only lead to a worse state than exists at present.

The Whiskey Problem.

THE terse question, "What is whiskey?" remains unanswered by the Appeal Court. The legal proceedings that have attended the prosecution and subsequent appeal have cost a great deal of money, but have brought no peace to the perturbed mind of the man in the street. If he asks for whiskey at a bar is he entitled to have spirit made from the original pot still or "silent" spirit from the modern substitute, the patent still? Alas, for all who indulge in whiskey, the magistrates say that they must have pot still spirit, but the final authoritative decision of the higher court is not yet given, perhaps never will be forthcoming. It may be that sufficient guidance on the point may be secured from the fact that the principal distillers in England, Ireland and Scotland insist that pot still whiskey is the original and best article, a view we have all along supported in these columns. In any case it seems to us that a man is entitled to know what he is buying. Patent still whiskey is far cheaper than the pot still product. That fact cannot be gainsaid by the most ardent supporter of the patent still. Under these circumstances the course pursued by Messrs. W. and A. Gilbey appears to be straightforward and sensible. They sum up the matter in the following nutshell:—"If a customer desires Scotch or Irish whiskey he should not be served with a cheap substitute on the plea that it is good for him. If, on the other hand, he is content to accept the cheaper article, he should not be charged a high price for it on the assumption that it is 'fine old Scotch or Irish whiskey.'" Messrs. Gilbey, therefore, have adopted the simple plan of selling both kinds under labels stating whether the bottle contains pure malt pot still whiskey or pot still blended with patent still spirit. This solution of the difficulty reminds us somewhat of the downright tactics of the warrior who cut the Gordian knot he could not unravel.

Why Go To Foreign Spas?

THE fires of patriotism illumine with fierce light many topics connected with trade and agriculture. Numerous other things of equal importance, however, they leave alone in the shades of cold obscurity. Take the case of the spas and watering-places of England, Scotland, Ireland and Wales. There is hardly a known medicinal virtue, whether of earth, sky or sea, or of the waters beneath the earth, that cannot be obtained in some part or other of the United Kingdom. A moment's reflection will show this to be the case when one recalls the fame of Bath, Harrogate, Tunbridge Wells, Matlock, Woodhall Spa, Llandrindod Wells, Strathpeffer, and many other equally noted mineral springs in Ireland, Scotland and Wales. The seaside resorts of the United Kingdom, again, offer every possible variety of attraction as regards climate and other health-giving conditions, not to mention fairy-land beauties of sea and shore. The Balneological Society of Great Britain has done a great deal to draw attention to our neglected health resorts. It would be well were the spirit of domestic patriotism diffused more widely among the medical practitioners and the laity of the United Kingdom, so far as spas and other health resorts are concerned.

The Most Insanitary District in the Kingdom

THE exposure of the sanitary circumstances and administration of the urban district of Merthyr Tydvil made in the just-issued report of Dr. J. Spencer Low, of the Local Government Board, would no doubt astonish the public if only they could be induced to pay any attention to it; but it is not likely to surprise any one sufficiently acquainted with the defects of sanitary administration as it is conducted by a great proportion of the local authorities throughout the country. Merthyr Tydvil has perhaps gained the unquestionable right to the title of the most insanitary district in the kingdom, but there are a whole crowd of places—urban and rural—whose claims to a similar distinction are not much less weighty

Almost every single defect injurious to the public health has existed in Merthyr Tydvil for many years. They have been reported on over and over again by the Medical Officer of Health, and even by sub-committees of the Council, but no action has been taken upon the reports. It is no wonder that Dr. Low declares it to be obvious that there has been an obstructive element in the Council sufficient to shelve for a number of years the remedying of evils which have been yearly pointed out in a most insistent manner by successive medical officers of health. We need not now analyse the death-rate of the town; our main object is once more to emphasise the fact upon which we have often insisted that the blame for the shocking disregard of duty displayed by too many local authorities rests upon the general public. Local authorities are what the citizens and ratepayers choose to make them. The remedy, and the only complete remedy for existing abuses is to turn out inferior members of governing bodies and replace them by men incapable of sacrificing the welfare of their fellow citizens through ignorance, if not in pursuit of sordid and selfish ends. There exists in these islands very little of the municipal corruption such as disgraces the United States, but the prevailing apathy, the lack of local patriotism, the disinclination of the wealthier classes to make any personal sacrifice for the good of the community, constitute a danger to the State.

Immunisation against Tuberculosis.

RECENT investigations demonstrate the possibility of protecting young calves against tuberculosis by the administration in food of bacilli that have been killed by boiling or other application of heat. The results have been confirmed by several trustworthy authorities and only two points remain to be cleared up for the method to be applied on a large scale, viz., the duration of the immunity thus procured and the possibility of obtaining similar results in human beings. Certainly a means of immunisation would have a great future that is devoid of risk in a form that admits of being taken by the mouth, thus avoiding the risks inseparable from subcutaneous injections. Now, milk is the only food likely to contain tubercle bacilli that is consumed raw, and the importance of boiling it as a routine prophylactic measure is emphasised by the fact that the milk of tuberculous cows, especially those suffering from tuberculous lesions of the udder, becomes, by boiling, an immunising agent of the first order, indeed the richer the raw milk in bacilli the more active its protective properties when boiled. It may be well that in the near future milk will be deliberately "guaranteed rich in bacilli," and cows will be injected with tuberculin in order to select animals proved to have the disease. The idea is gaining ground that the air passages are, after all, not the ordinary channel of tuberculous infection, since numerous experiments have shown with what facility tubercle bacilli, when administered with food, find their way into their happy hunting ground, the lungs. Should this supposition prove to be correct, it would by no means invalidate the necessity of preventing the dissemination of the tubercle bacillus in the form of dust; for whether swallowed or inhaled the results are in the highest degree dangerous. It is infinitely probable that the bacillus selects the path of least resistance, and while in the very young this appears to be *via* the digestive tract, in older persons the lungs are likely not only to be more accessible, but also more vulnerable.

The Public Health of Belfast.

DURING the past few weeks a hot controversy has raged in Belfast over the appointment of a Medical Officer of Health to succeed Dr. Whittaker, who has recently resigned. The medical profession and the newspapers generally have strongly urged the appointment of a specially trained medical man, experienced in public health work, to whom an adequate salary should be paid. A deputation from the Ulster Medical Society, which recently waited on the Corporation, drew attention to the fact that the death-rate in Belfast is extremely high, and that up to the present there has been no adequate sanitary department. The Public Health Committee, while denying that the health of the city is in an unsatisfactory condition, recommended that a salary of £800 a year should be attached to the office of Medical Officer of Health. The Corporation has decided, however, that £600 is sufficient, and it is rumoured that this decision is intended to limit the number of expert candidates in order to give the post to a gentleman recently a member of the Corporation. It is hardly credible that in a prosperous and progressive city like Belfast such an important decision as is here involved should be influenced by improper motives. Cardiff and Leeds each pay their medical officers £800 a year, and give him trained assistance. Liverpool pays £2.500 in salaries to the medical officer of health and his assistants, and Manchester a nearly equal sum. These are the cities with which Belfast should compare itself, and we trust it is not yet too late to admit of suitable arrangements being made for the care of the lives of its citizens.

Population and Emigration.

THE report of the Departmental Committee on Emigration appointed about a year ago by Mr. Lyttelton, then Secretary for the Colonies, has just been published. The report brings into prominence and emphasises the fact upon which we dwelt in an article a week or two ago upon the conference on Infantile Mortality—the fact, namely, that the efforts of statesmanship ought to be first of all directed to removal of the true prime causes of degeneracy. If the bulk of our increase were composed of men and women physically, mentally and morally fit there could be no difficulty in providing for them. All our

Colonies are crying out for population ; they are ready to absorb all our surplus people, but object to receive them in the form of wastrels, degenerates and unemployables. The problem at home is thus to prevent the breeding and rearing of these classes. This is to a large extent to be accomplished by application of the sanitary laws which have been placed upon the Statute book within late years, but which in most localities are not properly administered. The mortality among infants is, as we have so often insisted, an index of the amount of degeneracy among the survivors. The main factors in the causation of the mortality are well known, and being preventable, ought to be prevented. The Poor-law, as at present administered, tends to the creation of chronic pauperism, and this is especially true of the vagrancy problem. Professional tramps and vagabonds of all classes drag about with them thousands of children who are moulded into a form which unfits them for any but a life of idleness and crime. It seems a pity that Parliament cannot take in hand the details of these phases of the social problem, and apply the obvious remedies. The report of the Vagrancy Committee has been out for some months ; perhaps when the Royal Commission on the Poor-law, which is still sitting, shall in turn have issued its report the subject may receive the attention it so urgently calls for from the Legislature.

The Tinned Meat Scare.

IT is to be hoped that the public will learn some useful lessons from the revelations which have been made concerning the conditions under which potted meat is prepared in Chicago. Already there is a natural, though somewhat illogical revulsion of taste from imported to home-prepared preserved meats, it being assumed that the English factories are managed in a perfectly satisfactory manner. Though it is likely that at least some of the Chicago horrors are unknown in this country, yet if this be so it is in no way due to the precautions imposed by the community, but rather to the different business habits of our manufacturers. As a matter of fact, the inspection of meat factories is not of such a nature as to ensure that only sound meat is used. The inspection of imported meat is of necessity still more unsatisfactory. It is impossible, in the great majority of instances, to tell without opening a tin, whether the contents are putrefied or not, and the examination of every tin is an impossibility. Moreover, the dangers to be feared are not always those arising from the presence of bacteria or the ptomaines produced by them. It not infrequently happens that tin or lead is present in appreciable quantity in the contents, though its presence is not likely to be discovered or even suspected without chemical examination. It would seem that it is impossible to ensure a perfectly safe supply of imported tinned meats, so that it is all the more necessary that the home-prepared material should be above suspicion.

PERSONAL.

DR. F. B. CROSBY, who was last week elected one of the Sheriffs of the City of London, is in active practice as a physician. He entered the Common Council in 1877, and was elected Alderman in 1898.

THE honour of Knighthood has been conferred upon Professor A. E. Wright. From 1892 to 1902 he was Professor of Pathology at the Netley Army Medical School, and was a member of the Indian Plague Commission, 1898 to 1900. He has done much scientific work, and in 1897 was appointed Pathologist at St. Mary's Hospital.

DR. ROBERT FARQUHARSON, whom His Majesty has created a Privy Councillor, is well known as the medical officer to Rugby School, assistant physician to St. Mary's Hospital, and lecturer on materia medica. His chief work is the well-known "Guide to Therapeutics."

SIR CHRISTOPHER NIXON, whom the King has created a baronet, is a distinguished Irish physician, who has been president of the Royal College of Physicians in Ireland, as well as of the Royal Veterinary College in that country.

AMONG the Birthday honours bestowed by His Majesty, few are more deserved than the Knighthood conferred upon Professor Alexander Russell Simpson, M.D.,D.Sc., who was born in 1835. He was from 1870 till 1905 Dean of the Faculty of Medicine and Professor of Midwifery and Diseases of Women and Children at Edinburgh University. The baronetcy of his uncle, the famous Sir James Simpson, is now held by a cousin of Sir Alexander Simpson.

DR. E. M. WILKINS has won the annual challenge cup of the Manchester and District Medical Golfers' Association.

PROFESSOR H. S. F. GRUNBAUM has been elected Dean of the Faculty of Medicine and Chairman of the Board of the Medical Faculty of the University of Leeds in place of Professor de Burgh Birch, who has resigned.

THE coming retirement is announced of Mr. F. T. BUCHAN from the position of Poor Law Inspector of the Local Government Board for Wales and Monmouthshire.

THE Raymond Horton-Smith prize for the best M.D. Thesis in the University of Cambridge has been awarded to Harold Theodore Thompson, M.D., B.C., of Christ's College, "On Certain Changes in Sensation associated with Gross Lesions of the Spinal Cord."

DR. FREDERICK TURNER, J.P., medical officer of health at Buxton, has resigned his post, which he has held for thirty years.

WE regret to announce that Dr. Robert Craik, who was for many years Dean of the Medical Faculty of McGill University, died last week at Montreal at the age of 77.

PROF. T. GREGOR BRODIE, F.R.S., is announced to give a course of five lectures at the "Brown" Animal Sanitary Institution (University of London) during the present month ; the dates and subject of which will be found on reference to our advertising columns.

SIR CONSTANTINE HOLMAN has resigned his position of treasurer of Epsom College, which he had occupied for nineteen years. Fifty-one years ago he took part in the initiation of the College. In 1887. when he became treasurer, there were 191 pupils, as compared with 254 now.

A CLINICAL LECTURE
ON THE
VALUE OF PHILIPOWICZ'S AND BERNARD'S SIGNS IN THE DIAGNOSIS OF TYPHOID FEVER.

By Professor LOUIS REGIS, M.D., of the Faculty of Medicine of Paris.
[Specially reported for this Journal.]

A CASE of typhoid fever with pneumonic complications in a child, æt. 4, affords me an opportunity of discussing with you the clinical value of two clinical phenomena which so far have been very inadequately studied in this country, and to which in any case too little importance is at present paid. The young patient, aged four years was brought to me by his mother on September 5th, 1904. She informed me that the little man had just returned to Paris after passing three weeks in the country, where he had enjoyed the best of health until he was on the point of undertaking the return journey. Just at that time he complained of feeling tired, he lost his appetite, he coughed, had diarrhœa with slight fever, and passed very restless nights.

The child's flushed face, his unequally coloured cheeks, and a rather marked shortness of breath made me at first suspect a pulmonary affection. I auscultated him, and on the right side I discovered the existence of a typical pneumonia with its ordinary clinical associations. Continuing my examination, I noticed that the spleen was somewhat enlarged and sensitive to pressure, and that there was gurgling in the right iliac fossa. Lastly, the palms of the hands presented a distinct yellowish coloration. The rectal temperature was 40° C. (104° F.).

Although, it is true, the pneumonia that I had discovered might *a la rigueur* suffice to explain the whole symptomatology, including the abdominal signs, the more so seeing that the little patient, whom I had already attended for measles, gastro-enteritis, and membranous enterocolitis, was very subject to intestinal disturbances, the state of the stomach and especially the yellowish coloration of the palms forthwith suggested to me the possibility of typhoid infection.

I therefore postponed any diagnosis until the following day. I ordered a mild purgation and hot moist applications with, every three hours, a mixture containing acetate of ammonia, enjoining at the same time a milk diet. On the following day I made a fresh examination. The palms of the hands and the soles of the feet exhibited a well-marked yellow coloration almost like that of jaundice (Philipowicz's sign), and on deep palpation of the ileo-cæcal region I discovered two swellings which gave the sensation of movable glands, the size of a filbert (Bernard's sign).

The family were not in affluent circumstances, so that we could not instal a bath; moreover, the patient could not be properly isolated, so having diagnosed typhoid fever I advised them to have the child removed to the nearest hospital. The child was admitted on account of the pneumonia, the mother's assurance of the existence of typhoid fever to the contrary notwithstanding. It was only on the fourth day after his admission that the disease was identified as typhoid, and that the usual treatment was instituted. The disease ran its course in about six weeks, and I ascertained subsequently that the belated diagnosis was based on the sero-reaction.

Here, then, gentlemen, was an unquestionable case of typhoid fever which presented all the clinical appearances of an attack of pneumonia, but which I had been enabled to diagnose without the assistance of any of the many ingenious laboratory reactions, that is to say, I had suspected it on the fifth day and had confirmed my suspicion on the sixth. If I insist on the dates it is in order the better to emphasise the very great value of these two signs which I will now proceed to discuss in detail, epitomising the researches and criticisms of which they have been the object during the last few years.

In 1903, Philipowicz, in the course of an epidemic of typhoid fever at Odessa, noticed that all his patients presented a more or less well-marked yellow coloration of the palms of the hands and the soles of the feet. This coloration, which persisted in spite of washing and scrubbing, was most pronounced on the prominent parts, the thenar and hypothenar eminences, the finger tips, the heel and the internal and external plantar region. Moreover, the callosity of the hands and feet seemed to reinforce the colour, turning it to orange and even to saffron yellow. Lastly, the colour faded aud disappeared as recovery took place.

For a long time Philipowicz made comparative observations of the hands of his typhoid patients and those of his other patients suffering from various affections, and he found that the coloration was peculiar to enteric patients. After nine years of patient research and comparison he published a detailed description of the "palmo-plantar sign," a descriptive title which, in conformity with the objectionable practice of naming things after the names of their discoverers, is now known as "Philipowicz's sign."

The pathogenesis of this sign is still quite obscure. Philipowicz believed it to be due to the intoxication of the organism by the toxins of the bacillus of Eberth. According to him these toxins modify the circulation, consequent upon changes in cardiac activity, and so bring about a slowing down of the circulation in the cutaneous capillary system. He based this belief on the dicrotism of the pulse, the frequent disproportion between the pulse-rate and the temperature, the pallor of typhoid patients, and the dryness of the skin. This diminution of the blood in the cutaneous capillaries may very well be dependent upon the hyperæmia of the mesentery, the spleen and other organs in the abdomen. The palms of the hands and the soles of the feet, receiving an inadequate supply of blood, undergo a degree of atrophy and allow the yellow colour of the subcutaneous layer of fat to show through this layer, being especially abundant in the prominent parts of these regions.

This explanation is not admitted by most authors who have studied the subject. Motta Coco and Quintin attribute the phenomenon to a simple local inflammatory process or to the local action of the typhoid toxins, while Gilbert and Hercher explain it in accordance with their own views of hæmapheism.

Philipowicz attaches a pathognomonic diagnostic value to this sign as well as a prognostic value, the severity of the attack being, according to him, in proportion to the intensity and the precocity of the coloration.

This symptom has been the object of much critical study in Italy, more particularly by Baccarini, Querola, Lacchesini, and Motta Coco, whose remarkable monograph on the subject terminates with the following generally admitted conclusions :—

(1) The palmo-plantar sign is almost invariably present in enteric patients. It is most constant in children, then in women, and, lastly, in men. (2) The palmo-plantar sign usually makes its appearance during the first seven days, more rarely in the course of the second week. It disappears when convalescence sets in, but promptly reappears in the event of a relapse. (3) The palmo-plantar sign possesses great importance in the diagnosis of typhoid fever without, however, being entitled to be regarded as pathognomonic. It has no prognostic value. It may be present or absent, be well-marked or very slight, in mild as well as in grave cases.

From these data you will gather that this palmo-plantar sign, so readily discoverable, possesses a well-nigh pathognomonic significance when its presence is associated with certain other early signs of typhoid fever.

Peculiár to infancy, the second symptom, much more recently discovered, is even less well-known among us. The credit of its discovery belongs to Dr. J. Bernard, of Zychyfalva, in Austria, who first described it in 1902. To find it we must carefully and methodically palpate the right iliac fossa, especially in the ileo-cæcal region. In a typhoid patient we shall feel two or three small swellings varying in size from a filbert to an almond. These tumefactions lie parallel to the longitudinal axis of the colon at a distance of from half to one inch from each other. They do not become perceptible until the end of the first week, and usually disappear some days later.

The presence of these tumours has been attributed to hypertrophy of Peyer's patches and inflammation of the mesenteric glands. This last hypothesis seems quite inadmissible, by reason of the anatomical situation of the mesenteric glands, which, when enlarged, would be felt to lie horizontally, whereas the enlargements in question are more vertical. Peyer's patches may all the more plausibly be incriminated, seeing that the size of the swellings corresponds thereto, and that they are parallel to the axis of the intestines, especially if we bear in mind that the anatomo-pathological process in the young is hyperplasic in contrast with the necrobiotic tendencies of typhoid fever in the adult.

This, gentlemen, completes my description of these two signs. With regard to the palmo-plantar sign, in view of its almost invariable appearance at the very onset of the disease, and the ease with which it can be ascertained, one cannot but experience a feeling of surprise that it should not already have acquired a more prominent place in typhoid symptomatology. It will, I am convinced, assist you greatly in your future career in the diagnosis of a disease which always comes upon us more or less as a surprise and with regard to which we cannot have too many means of control.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The Lecture for next week's issue will be by Charles Barrett Lockwood, F.R.C.S.Eng., Surgeon to St. Bartholomew's Hospital, London, President of the Harveian Society, "On Carcinoma." Lecture delivered at St. Bartholomew's Hospital, May 23rd, 1906.*

ORIGINAL PAPERS.

SOME EXAMPLES OF CONGENITAL HYPERTROPHIC STENOSIS OF THE PYLORUS.*

By GEORGE CARPENTER, M.D.Lond.,

Physician to the North Eastern Hospital for Children, Membre Correspondant de la Société de Pediatrie de Paris.

THE following cases are narrated as a contribution to the study of congenital stenosis of the pylorus.

This uncommon condition has of recent years received a good deal of attention at the hands of various writers, and from time to time isolated examples of the complaint together with more elaborate communications have been recorded in medical journals at home and abroad. But the condition is a rare one, for there are many children's physicians in large practice and with an extensive experience of children's ailments who have never met with a case. Moreover, cases that appeared to possess all the symptoms and local characteristics of the disorder have been published from time to time, and who have apparently completely recovered from the complaint by judicious feeding and by medical measures. But such cannot be considered above suspicion, for there are many opportunities of falling into error and being deceived. On the other hand, pathological specimens removed from the bodies of those presumed to be suffering from the complaint have not always appeared to us to warrant such a diagnosis from their morbid appearance. There can be no question, however, as to the correct diagnosis of my cases, for they were in each instance verified by surgical procedures, and unfortunately confirmed by *post mortem* examination.

Edward J——, æt. 3 weeks, was sent by Dr. Douglas Wright to Dr. George Carpenter and was admitted into the North Eastern Hospital for Children on June 8th, 1905. The child was full term and the sixth pregnancy. There had been neither miscarriages nor still births. The weight at birth was 8¾ lbs. It started vomiting on June 1st, when a fortnight old ; since then it had been sick after almost every feed. Occasionally three feeds were passed by without sickness, but then it vomited a large quantity. Specks of blood were noticed in the vomit, but the mother had a sore nipple. At times the vomit was brown, like beef tea. The bowels were natural until the commencement of the vomiting, when they became costive. Soap enemata were followed by a small bright green stool. The last motion was sage green in colour and of a uniform tarry consistency.

On admission.—A hard tumour the size of h e terminal phalanx of the little finger was found deep down in the abdominal cavity above and to the left of the umbilicus. The infant was weighed on June 12th and found to be 6¼ lbs., a loss of 2¼ lbs. since its birth. Since its admission it had vomited from 5 to 8 times in the 24 hours. It was given a mixture

* Pathological specimens exhibited at the Society for the Study of Disease in Children, October 20th, 1905, and January 19th, 1906.

of milk and barley water by the mouth, 1¼ ozs. at a time.

June 15th. Since admission the bowels have acted irregularly—on three days once or twice in the 24 hours and of a dark green colour, at others not at all. Vomiting as before. The temperature has been subnormal On June 17th, visible peristalsis was first noticed. The child's eyes looked sunken and it was obviously

FIG. 1.

wasting. The temperature ran up to 101·2° F. Nutrient enemata were ordered. The stools were a little more frequent; the sickness as before. On June 19th, Mr. Ewen Stabb saw the patient with Dr. Carpenter and it was decided that the pylorus, which felt as hard as iron, should be freely dilated. The stomach was opened by a longitudinal incision. The stricture would just admit a No. 4 gum elastic catheter. The pylorus was dilated by a pair of blunt ended dressing forceps. When the dilating was finished the little finger could be passed through the pylorus with ease. A soft catheter was pushed into the duodenum and a feed of milk and brandy administered. The stomach was sewn up with Lembert's sutures. Owing to the stony hardness of the tumour pyloroplasty was thought impossible of performance and the simplest operation selected in view of the child's critical condition. The child was collapsed afterwards. The temperature at this time was normal. On June 20th, mouth feeding was stopped owing to sickness which occurred after and between the feeds. Albumen water was given by the mouth a teaspoonful every half hour. June 21st, albumen water and about half the rectal feeds retained. Temperature raised since the operation this evening to 102°F. June 22nd, Wound dressed. The infant is becoming more wasted and the eyes more sunken. Taking milk and barley water by the mouth. Since the operation has vomited from 2-4 times in the 24 hours and the bowels have been opened from 2 to 4 times. Temperature 103·5°F. June 27th. He had lost 1¼ lbs. in weight. Vomiting occurred but once on this date, once on the 26th, not at all on the 25th, but 4 or 5 times on the 23rd and 24th. The bowels were opened from 3 to 5 times in the 24 hours, loose and black stools. The temperature was about 100°F. Mr. Sydney Stephenson was asked to examine the infant's eyes and reported that there was a septic ulcer taking up two thirds of the right cornea, with protrusion of Descmet's membrane. On July 2nd, the ulcer perforated and the lens was found under the upper lid. In the meanwhile the child had been sick from 2 to 3 times in the 24 hours and the bowels had been opened from 4 to 11 times. The temperature had been subnormal with one or two exceptions when it rose to 100°F. He died on July 4th, the *post mortem* examination was made on July 5th. The wound had not healed. The infant was greatly emaciated. All the organs were normal. The pylorus was as described on physical examination. On filling the stomach with water none passed through the pyloric opening. The stomach held 4 ozs., the whole of the intestines were collapsed. The right eye was completely disorganised from suppuration. The child evidently died of starvation.

CASE 2.—Annie D——, æt. 5 weeks, the first infant, was a fine child at birth. She was fed on the breast and had occasional attacks of sickness. When a fortnight old she was put on the bottle. When 3 weeks old she had wasted "a good deal." Proprietary foods were then tried and later sterilised milk, but nothing seemed to suit her. By the fourth week she was much worse and either vomited every feed or accumulated feeds in the stomach and then "pumped them on the floor." She was always constipated. She was admitted into the North Eastern Hospital on July 10th and looked somewhat wasted but she weighed 7¼ lbs. A lump was felt in the region of the pylorus. Under an anæsthetic, which the child took badly, the lump was found to be of cartilaginous hardness and it was grooved transversely. It was thought to be about the size of the terminal phalanx of the index finger and the stomach walls in its neighbourhood also felt thickened. The intestine (duodenum) also was thought to be somewhat thickened. After the examination the infant was fed by nutrient enemata. Water was given by the mouth and 10 minims of brandy hourly, as it had a very poor pulse. It was sick 4 times. On the morning of July 11th, just before the operation, the pulse was weak and the child was somewhat cold. A hypodermic injection of brandy was given. Ether was administered. Mr. Lockhart Mummery operated and the appearance of the pylorus tallied with the description already given. The growth

FIG. 2.

FIG. 3.

was of cartilaginous hardness and the thickening extended chiefly along the greater curvature of the stomach but also along the lesser. Mr. Mummery deemed it impossible to perform pyloroplasty and anterior gastro-enterostomy was done, the operation taking 25 minutes to perform. The infant was returned

from the theatre in a collapsed state and very soon afterwards it started continuous vomiting of blood, not in any great quantity at a time, but it lost a good deal in small amounts. A solution of adrenalin (Adrenalin solution 1 drachm, normal saline solution 5 drachms, standing on ice); minims 10 every hour by the mouth stopped the bleeding. The child was fed by the rectum. In the afternoon the temperature began to rise rapidly and the child became worse. Stimulants were withheld and morphine gr. 1·200 was given hypodermically. The pulse became more and more feeble and the child died at 6 p.m., the temperature having risen to 103·8°F. At the autopsy the body was somewhat wasted. The organs were normal. A section of the pylorus measured half-an-inch across, the increased thickness to the naked eye appearing to be almost entirely muscular fibres. There was also considerable hypertrophy of the muscular wall of the stomach over the pyloric third.

The pathological specimens were handed to Dr. P. L. Hipsley for further observations and he reported as follows. In Case I. there was nothing unusual about the shape or size of the stomach. The capacity in moderate distension was found to be 4 ozs. (*vide* Fig. 1). The wall was thicker than normal throughout, but the thickening was most marked in the pyloric fourth. The pylorus itself formed a tumour ¾ in. long and about ½ in. thick, being definitely marked off from the duodenum, but tapering away gradually into the stomach wall. On opening the stomach along the anterior wall midway between the greater and lesser curvatures and continuing the opening through the pylorus, the wall of the latter was seen to be about ¼ in. thick, and at its junction with the stomach wall it tapered down to about ⅛ in. A No. 4 catheter could be passed through the sphincter. The portion of the sphincter projecting into the duodenum looked remarkably like the cervix uteri.

Microscopical examination.—On microscopical examination the principal feature to be seen was the hypertrophy of both the circular and longitudinal layers of muscular fibres. The former was five or six times its normal thickness, and the latter was also hypertrophied, but not to the same degree, being perhaps two or three times its usual thickness. The distinction between longitudinal and circular layers was not so sharply defined as in the normal condition. Here and there towards the inner portion of the longitudinal layer bundles of circular fibres could be seen, and in places, moreover, bundles of fibres from the longitudinal layer penetrated the circular and traversed it in different directions and for variable distances. The muscular bundles of both layers appeared to be very densely packed and there was an increase in the amount of fibrous tissue which is usually seen traversing the circular layer. These fibrous bands are very well demonstrated by staining with the Van Gieson mixture, which stains fibrous tissue pink and muscular tissue a yellowish colour. The mucous membrane appeared to be natural, but the submucous layer was thicker than normal and the muscularis mucosæ was distinctly hypertrophied. Very little round cell infiltration could be seen in either submucous or muscular coats. There were no vascular changes to be seen.

The stomach of Case II. presented features very similar to those described in the first case. There was no marked dilatation, if any at all, although unfortunately the actual capacity of the organ was not estimated. The stomach wall was very much thickened in the pyloric fourth, much more so than in the first case. The pylorus formed a tumour about the size of the last joint of the ring finger. (*vide* Fig. 2). A microscopical examination of both the thickened stomach wall and pylorus was made. The latter presented features identical with those described above. In the stomach wall three layers of muscle could be seen. The inner circular layer was about equal to the thickness of the other two combined. All three layers were hypertrophied. The mucous membrane presented nothing noteworthy, but the submucosa was undoubtedly thicker than normal.

CASE III.—Alice B——, was admitted into the North-Eastern Hospital for Children on January 1st, 1906. Her age was 4 weeks, and she was thin but not markedly wasted. She was born fat, and appeared healthy, but ever since the first two days after birth she had been "sick after each feed." She was breast-fed. A week prior to her admission she "vomited immediately after nursing." Her bowels had been confined, and when opened the motions were like "green water," and for three days before she was brought to hospital she had had no action. Another child died of wasting at three months old, fourteen years before. On admission she weighed 5¼ lbs., the pulse rate was 96 to the minute, the respiration rate 32 and the temperature 97° F. Soon afterwards she vomited a large quantity of undigested milk, much more than the previous feed would account for, and the bowels acted freely. A lump was found in the abdomen, about the size of the terminal phalanx of the little finger, hard but not of stony hardness, and with a ridge round it acorn-like. It lay above and to the right of the umbilicus, deep down in the abdominal cavity, very deep, right on the spine, and could be grasped with difficulty between the finger and thumb. When grasped it was obvious enough but it would have been quite easy to miss it, and it required the exercise of great care and patient manipulation for its detection. The stomach walls also felt thick. The child was first examined without an anæsthetic, but subsequently chloroform was administered without, however, facilitating the examination. There was visible peristalsis of the stomach, and this could also be produced by flicking the abdominal walls. Apart from the condition of the pylorus nothing abnormal was found. She was ordered a whey and cream mixture and the stomach to be washed out twice daily. On January 2nd she was sick three times, and the bowels were opened once. She was taking a mixture of tincture of opium, a third of a minim thrice daily for a dose. On the 3rd she vomited eight times and the bowels were not opened. She had lost half a pound in weight since admission. On the 4th she vomited twice directly after being fed. The bowels were opened three times. She had gained ¼ lb. in weight. Olive oil was given in place of the cream, sufficient to make a mixture containing 3 per cent. fat. On the 5th she lost 1 oz., on the 6th, 2 ozs., and on the 7th the weight remained stationary at 5¼ lbs. The olive oil in the milk mixture was thought not to be a success on account of the sickness which had increased to nine times on the 5th, with one exception immediately after feeding, and as on the 6th the vomiting had not improved much it was omitted and cream substituted. On the 7th she vomited eight times, mostly after feeding, and twice the vomit was a "brown fluid." During this period stomach washings were continued, and saline injections were given by the bowel. Albumen water was substituted on this date for the whey mixture. The bowels acted twice daily on the 5th, 6th, and 7th. She retained the albumen water much better than the whey and cream, and only vomited once or twice and in small quantities. Although there had been no further loss of weight, the infant's appearance was not satisfactory, and it was weaker than on its admission. Dr. Carpenter therefore decided to have the child operated upon, the operation being performed by Mr. Ewen Stabb. Ether was administered by the open method, with the occasional addition of a few drops of chloroform. The pylorus was found to be very much thickened, hard and about the size of an almond nut. It was decided to perform a posterior gastro jejunostomy, the pylorus being thought to be too thick and hard for pyloroplasty. The stomach walls were considered to be thickened at the time of operation. Two ounces of whey were injected into the small intestine, which was contracted and looked empty; the stomach, on the contrary, required the withdrawal of some of its contents to facilitate manipulations. The abdominal cavity was well flushed out with normal saline, a quantity being left in the abdomen. The child vomited several

times and the pulse became very weak; on getting her back to her cot it was scarcely perceptible and a mixture of normal saline, adrenalin, and brandy were injected slowly per rectum.

This was not retained, so 8 ozs. of normal saline were injected into the subcutaneous tissue. This had a good effect on the pulse, which became stronger and able to be counted. But she continued to vomit frequently a dark brown material. After one of these attacks the pulse suddenly became worse and could be felt only occasionally; she did not rally and died five or six hours after the operation. *Post mortem*. The stomach was not dilated. Water poured into the

FIG. 4.

stomach through the œsophagus first distended the viscus which held 1¼ ozs., and then passed out slowly through the pylorus. When the funnel was raised to the height of two feet the fluid escaped by drops only. While the passage of fluid was slow the obstruction did not appear very great—five small knitting needles were passed through the pylorus easily, as also a No. 2 catheter, and the diameter of its lumen was 2 inches. The indurated pylorus measured ¾ in. by ½ in., and the stomach walls were thickened. The operation sutures held well and there was no leakage. There were no other abnormalities.

Remarks.—These cases, in respect to the cartilaginous hardness of the pyloric tumour and to the hypertrophy of the stomach walls, resembled a case recorded by myself and Mr. Lockhart Mummery in Vol. 5 of Reports of the Society for the Study of Disease in Children, pp. 242-245, two drawings being given, one of which I reproduce—*viz*., Fig. 5.—This patient, æt. 3 months, was operated upon by pyloroplasty, but died the following morning. The *post mortem* showed that a free opening had been established through the pylorus, and, mechanically, the operation was a success. It is not always easy to feel a hypertrophied pylorus, for the tumour is often deep down in the abdominal cavity and is apt to be missed on palpation, but by methodically squeezing the abdominal contents between the fingers and thumb the condition of the underlying viscera can be readily ascertained. This method of examining infantile abdomens, which is a very delicate one and yields admirable results, should always be practised as a matter of routine. In Case III. the thickened pylorus was especially difficult to feel, and the squeezing method of abdominal examination proved invaluable Loreta's operation was not attended by success in Case I. The infant recovered from the shock of the operation but the stenosis recurred and starvation from mechanical causes followed.

Case II. did not survive the shock of operation which took the same time to perform—viz., 25 minutes, as the case of pyloroplasty previously mentioned. The condition of the pylorus was much the same as in that case, and if pyloroplasty had been attempted the same result would have doubtless followed.

The operation in Case III. was as expeditiously performed as in Case I., but like it, death occurred from shock shortly afterwards. The physical condition of the infants could not be considered good in any of the cases, but regarding them in the light of examples of marasmus they had by no means reached that condition of body which is usually recognised as past hope of recovery. In the diagnosis of congenital hypertrophic stenosis of the pylorus too much importance must not be attached to the absence of characteristic vomiting—the retention of two or three feeds followed by their subsequent expulsion. Peristalsis of the stomach is not unknown in simple gastric disorders in infancy, quite apart from stenosis of the pylorus, and unsupported by other signs must not be taken to indicate the latter.

Perhaps the most important diagnostic sign is the detection of the pyloric tumour, but even this may prove a source of error, for an enlarged abdominal gland has been mistaken for this condition in an infantile dyspeptic and has been revealed surgically. While in my cases the medical treatment has not been successful, surgical measures have proved no less unsatisfactory. Unfortunately, the extent of the pyloric stenosis was such as to render the performance of a secure and permanent operation in quicker time an impossibility. On the one hand the infants were faced by slow starvation, and on the other by death from shock. But is there no middle course for these pronounced cases? Failing relief by a well-adjusted dietary free from coagulum, would it not be better to perform a preliminary jejunostomy, which could be done very quickly? Feed the child by the artificial opening until such times as it is better prepared to resist the shock, and then proceed to the major operation? I think so, and the next case that comes under

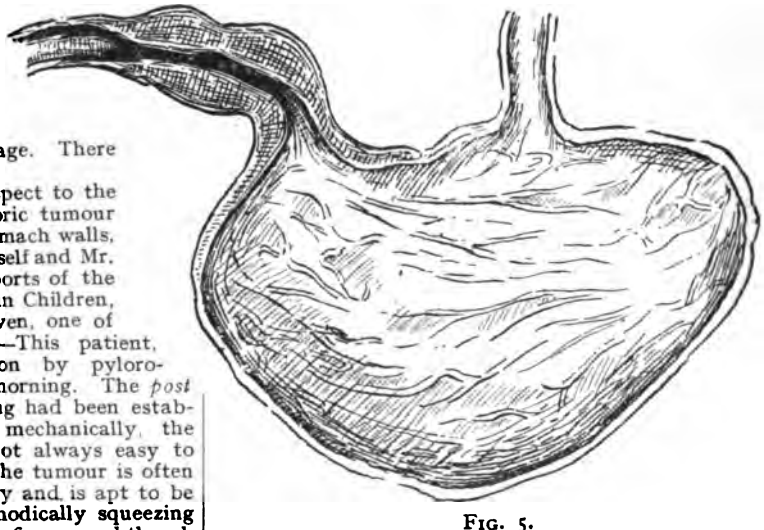

FIG. 5.

my care I shall adopt this plan. My thanks are due to Dr. E. Douglas Wolff for the photographs of Cases I. and II., and also for the careful records kept by him.

PLANTAR REFLEXES.

By W. B. WARRINGTON, M.D.LOND., F.R.C.P.,
Physician to the David Lewis Northern Hospital, Liverpool.

THE recognition in clinical medicine of the importance of the doctrine of reflex action is chiefly due to Marshall Hall, but the study of cutaneous reflexes at a later time became somewhat neglected, partly because the discovery by Erb and Westphal of the significance of the tendon reflexes, of which the knee-joint is the prominent example, led to such immediate advances in the study of nervous diseases. No such importance could then be claimed for the cutaneous reflexes, but in 1896 their study, and especially the study of the plantar reflex, received a remarkable impetus by the announcement of Babinski, a Paris physician, that there was an essential difference between the form of response to plantar stimulation in healthy or hysterical persons, and in those suffering from organic disease of the pyramidal tract, and that hence a boundary could be fixed between two domains, each of very wide extent. Numerous observations were made in all parts of the world, and papers on the plantar reflex still continue to appear. This fact, which also indicates that a settled value has not yet been assigned to the phenomena, is my apology for addressing you. Limit of time forbids my entering into the physiological side of the subject, and I shall confine my remarks to stating as briefly as possible the result of my own personal observations.

Method of observing the Reflex.—This is important. In all cases the patient should be lying down, with the knee bent and the muscles kept relaxed. The sole of the foot should be dry and warm, and its dorsum firmly grasped by one hand of the observer. If the patient is intelligent, he may often usefully be told that the sole of his foot is about to be tickled, and asked to concentrate his attention elsewhere. The instrument used for stimulation does not matter much—the finger, a wooden match, the point or head of a pin answer equally well. The stimulation is best made from the heel to the point of the foot. In the vast majority of healthy persons at least after several attempts, separated by an interval of time, a quick movement of the lower limb results, the tensor fasciæ femoris probably first contracts, and then, in rapid succession, the toes are flexed and adducted, the ankle dorsi-flexed and inverted, and the knee and the thigh flexed. This movement, when involuntary, is the normal plantar reflex, or flexor response. Not all the movements mentioned may take place; this depends on the strength of the stimulus, the irritability of the skin, the emotional state and capacity for attention of the person.

The movement of the toes is the important one. When thus taken, the reflex is rarely absent, but may be so, and this absence may be unilateral.

The reflex is absent in disease wherever the reflex arc of the first sacral nerve is interrupted, and also in complete transverse lesions of the cord. It is always absent in hysterical anæsthesia, and may be absent in that morbid condition even if anæsthesia is not present.

Quite different is the reflex described by Babinski. Here there is a deliberate slow extension of the great toe, usually associated with spreading or extension of the other toes, the further movements of the limb being much the same as in the normal flexor response.

I shall allude hereafter to this as the characteristic or typical extensor response, and I beg leave to ask your attention particularly to the slow and deliberate nature of the movement, since other varieties of extension are met with. These may have also a high value, but the same certainly does not belong to them. They will be mentioned as I proceed. One of the difficulties surrounding the clinical observation of the plantar reflexes is, that they may be closely stimulated by voluntary movement. The difference is better realised than described, but the following points may help. The true reflex is more mechanical in appearance; it commences and ceases suddenly, and the limb in a moment assumes its original position; a voluntary movement, on the other hand, sets in later, has not the same mechanical appearance, seems to be under some control, and the limb does not at once reassume its original position. I proceed to give an account of my observations in different diseases.

Disseminated sclerosis.—On account of the frequency with which young women are attacked by this disease, and the fugitive or anomalous nature of the opening symptoms, the extensor toe reflex was welcomed as a valuable sign for the distinction between this grave organic affection of the nervous system and hysteria. If present in the characteristic form, even in the absence of other symptoms, I should greatly hesitate to diagnose a purely functional condition; yet, in the cases I have so far met with, other symptoms, sufficient to put the observer on guard, have been present; 7 presented the classical picture of disseminated sclerosis; of these, 3 gave the characteristic response; in 1, combined with permanent hyper-extension of the great toe, an appearance always strongly suggestive of pyramidal disease; 1 gave a more rapid extensor response, in 2 alternation of extensor and flexor was present, and in 1 no reflex was obtained. The 5 remaining cases were probably atypical forms of the disease, and all gave the full, slow extensor response. In 1 the K.J. and A.J. were absent; here the presence of nystagmus, combined with extensor response, eliminated tabes; whilst this symptom, with the presence of partial optic atrophy, eliminated subacute combined sclerosis, leaving only the diagnosis of disseminated sclerosis. It is, indeed, in the differentiation of the different forms of organic disease that I personally have obtained most value from the sign.

Apoplexy.—The extensor response appears at once after the seizure, and was present in 9 out of 13 cases on the paralysed side. In 3 the plantar reflex was absent, and in 1 flexor in type. In apoplexy the response is usually more rapid and of shorter duration than the characteristic movement. It was in one of these cases that I obtained the extensor reflex in the toes by stroking the leg and thigh downwards. To a reflex thus elicited the names of planti-tibial and planti-crural have been given, and I think it is of considerable importance, but further investigation is much needed. On the non-paralysed side I found the flexor response in 10 cases, in 2 an extensor response, and in 1 the reflex was absent. It seems that the sign may give evidence as to whether a destructive lesion has invaded both sides of the brain, though it must be remembered that as the pyramidal tract on one side is in part in connection with both hemispheres, a double extensor response may be present in a hemiplegia, as in 2 of my cases, yet in 8 it was unilateral. It may also aid in distinguishing apoplexy from poisoning, though here much evidence is wanting, which can best be supplied by resident officers, to whom I respectfully commend this study. I am unable to attach any prognostic value to the presence or absence of the sign.

Meningitis.—The stimulation of meningitis in many fevers by the group of symptoms called "meningismus" suggested that the sign might be of value. It certainly appears to be often present in the former, absent in latter. Lumbar puncture is, however, a much more certain way of distinguishing between the conditions. My own observations are few. A rather rapid extension in two cases of tuberculosis, a flexor response in two of pneumococcal meningitis.

Transverse incomplete lesions of the cord.—In these cases the most characteristic response is met with. It was present in each of 12 instances, 5 being pressure from caries, 7 inflammation or softening of the spinal marrow. If the pressure is relieved or the primary disease subsides, the flexor response may return.

Complete transverse lesions of the cord.—The extensor response is here the only reflex that remains. It is, however, often absent, as in my 3 traumatic cases. In primary disease which has destroyed the whole transection of the cord its presence is often an important diagnostic sign, giving a clue to the original condition.

Gross cerebral disease of one hemisphere, other than

the result of old apoplexy. The nature of the reflex depends on the position of the lesion in the brain. It may be very serviceable, as in the following instance. A patient known from other symptoms to have a cerebellar tumour. Where was it situated? On the right side the knee and ankle jerks were absent, but there were very brisk cutaneous reflexes—abdominal, epigastric, and cremasteric—with the normal flexor response—a combination much opposed to that which is found when the pyramidal tract is interrupted. On the left side the reverse was found—brisk deep reflexes and extensor toe response, with the absence of cutaneous reflexes. The diagnosis was therefore made that the growth was on the right side, pressing on to the pyramidal tract before it had crossed. The correctness of the inference was demonstrated at an operation, and, unfortunately, later at the autopsy.

Post-epileptic coma.—The exhaustion produced in the cerebral cortex may suspend the functional activity of the pyramidal tract, and an extensor response result. It was so in 4 cases I observed. Its presence may serve to distinguish epilepsy from hysteria.

It was also present in one case of post-epileptic hemiplegia of long duration.

Cerebral diplegia.—Extensor response usually present, even when ankle clonus cannot be obtained; but it must be remembered that this form of response is normal to children before they can walk.

Tabes dorsalis.—Unless the pyramidal tracts are involved, the extensor response never occurs. The flexor response is the rule, but this is absent if there is much anæsthesia in the region of distribution of the sacral roots.

Peripheral neuritis.—Never an extensor reflex. The response is either flexor or absent if anæsthesia is present. Lastly, 2 cases may be cited illustrating its value in differential diagnosis:—

1. A patient under the care of Mr. Murray. Fracture of last lumbar vertebra. Had the cord or the cauda equina been damaged? The knee-jerk was absent on both sides, but ankle-jerk present, and characteristic extensor reflex. The inference was, therefore, that the lesion was in the cord at the third lumbar segment.

2. The reverse of this. Patient under Mr. Harrison's care. A man had been injured in the lumbar region. He was found to have an absent knee-jerk, but ankle-jerk present, with flexor response. It was inferred that the third lumbar root had alone been injured.

CONCLUSIONS.

1. The full, slow, deliberate extensor response is highly characteristic of organic interruption by the influences traversing the pyramidal tract, and has a value nearly approaching that of true ankle clonus. It does not occur in healthy adults when awake. It is constant in its appearance and easily produced, and cannot be well simulated by voluntary movement.

2. An extensor response, shorter in duration, of smaller range and more immediate in appearance, is usually found when the lesion of the pyramidal tracts is more physiological than anatomical, as in the exhaustion of the cortical cells after epilepsy, or the pressure of exudations, as in meningitis. It may be met with in slighter anatomical lesions, and is sometimes replaced by a flexor response. In such cases especial care must be taken to eliminate voluntary movement.

3. An alteration of flexion and extension may be obtained. In these cases, if the flexion and extension are of equal range and rapidity, great caution must be observed in the interpretation. The movement may be voluntary, or it may indicate a condition of pyramidal equilibrium due to slight damage, as described by Stanley Barnes. If the flexion, however, is very small in range, while extension is slower and larger in range, its significance must be carefully considered.

4. The reflex is absent in anæsthesia of the sole from any cause, excepting that resulting from complete transection of the cord.

5. The absence, when other considerations indicate a lesion of the pyramidal tract, is of no significance.

CLINICAL RECORDS.

THE WESTMORLAND LOCK (GOVERNMENT) HOSPITAL.

The Delivery of Women Suffering from Venereal Sores.

BY SEYMOUR STRITCH, L.R.C.P., L.R.C.S.,

Late Resident Medical Officer to the Hospital.

AT the meeting of the Obstetrical Section of the Royal Academy of Medicine, held on May 25th, the Master of the Rotunda Hospital read his annual report, and in it alluded to the delivery of women suffering from local venereal sores. In the discussion that followed, other gentlemen referred to the same subject, and described the prophylactic measures they considered necessary to prevent toxæmic infection arising during the puerperum. Dr. Jellett suggested that such sores should be curetted, and then treated with formalin.

As a former resident medical officer of the Westmorland Lock (Government) Hospital, I had the honour of announcing the results obtained in the treatment of such cases in that institution.

In his reply, Dr. Hastings Tweedy was good enough to say that such results as I had described were very interesting, and in his opinion they should be published. Encouraged by this statement, I now beg to submit the following particulars relating to the delivery of women in the Lock Hospital.

Through the courtesy of Dr. Henry FitzGibbon, Senior Visiting Surgeon to the Lock Hospital, I have been furnished with a table of statistics showing that there have been in this hospital 199 confinements in the course of the last ten years. These figures include cases of abortion, miscarriage, and full-term births, the greatest proportion consisting of the last-named. Amongst all these deliveries there were no maternal deaths. Only one patient developed serious symptoms with a high temperature as a result of septic absorption. Dr. FitzGibbon further states that no fatality occurred in the fifteen years preceding the ten just alluded to. That is to say, for a period of twenty-five years no lying-in women died in the Lock Hospital. Taking an average of twenty confinements per annum for twenty-five years gives us a total of 500 cases. In reality these figures should be greater, owing to the fact of the number of admissions to the hospital having decreased about 45 per cent. in the last fifteen years. If figures prove anything, or may be taken as a criterion as to the efficiency of any system in the treatment of patients, I think it must be conceded that women confined in the Lock Hospital are adequately attended to. The fact that only one case of septic fever occurred amongst 199 labours should be sufficient justification of the antiseptic precautions carried out in this institution.

Dr. T. P. Beddoes, Registrar of the London Lock Hospital, has very kindly sent me a letter in which he states: "This hospital is a private institution, and does not admit pregnant women, and if by accident they are admitted, as soon as their condition is ascertained they are discharged." Yet they have a certain proportion of abortions and confinements. Amongst these only one woman died, the cause of her death being placenta prævia, which accident can in no way affect our figures. Dr. Beddoes made his search through the records of his hospital to extend over a period of twenty-five years, with the result stated.

It will be noticed that the statistics of these two institutions, each covering a like period of twenty-five years, do not record a solitary instance of a puerperal patient succumbing from venereal causes. This exemption from general septic infection amongst patients suffering from venereal disease cannot be explained on the supposition that they may have been for some time in hospital and under treatment, for, as in ordinary lying-in hospitals, it frequently happened that these women were admitted towards the end of the second stage of labour.

Though speculative theories are beyond the province

of this communication, I might be permitted to say that the natural flushing of the genital tract by the liq. ammonii is at least not the essential factor of this exemption from general infection. This was illustrated by a case admitted to hospital in whom the "waters" had accidentally burst and dribbled away before the "os uteri" showed any signs of dilating. This patient had a lingering labour of about thirty-six hours' duration, yet her convalescence ran a normal course. It was supposed that driving in a cab from the Rotunda Hospital, where she stated she had been refused admission, had caused the membranes to rupture.

Until March, 1903, t ere were no special facilities for the delivery of women in the Dublin Lock Hospital, certainly there were none till the close of my residency, when a labour ward was opened. Previous to this, the confinements were conducted in a common ward, the patient being merely moved from one bed to another on the completion of her labour.

Nor were these patients in any way isolated from the others, whom I think may all be described as being "septic" in the Rotunda interpretation of the word. They enjoyed no such privileges as private bed-pans. In fact, beyond the temporary disturbance and excitement entailed by their actual confinements, things continued in much the same way as before. They, however, now became the patients of the resident medical officer, and had their diet changed to suit their altered condition.

The preparation of a woman entering on labour was supervised by the maternity nurse, who was, I believe, one of the most thorough, reliable, and efficient midwives who ever obtained a diploma in the Rotunda Hospital. This nurse, Nurse Halpenny, had over twelve years' experience in nursing Lock Maternity cases. I, for one, of the "residents" whom she passed through her hands, deem myself fortunate in having been initiated by her into the best means of avoiding accidental inoculation of oneself, whilst at the same time learning how to successfully prevent septicæmia in the patient. Nurse Halpenny's experience being so extensive, I never interfered in the conduct of a confinement unless some special indication for instrumental or manual assistance became apparent. According as a patient had no discharge or local sores, or had a simple catarrhal discharge, or suffered from a purulent blenorrhagia and a septic condition of the parts, Nurse Halpenny varied her procedure.

In the first instance, she satisfied herself with a most thorough cleansing of the patient's pudendum, perineum, and thighs. In the second instance she added douching of the vagina with a solution of perchloride of mercury. Whilst, in the third and most important class of cases, she substituted for the douching a gentle prolonged syphon irrigation of the vagina, lasting not less than twenty minutes. After this and during the continuance of labour, the parts were repeatedly flushed by turning on the syphon. These means were supplemented by using a generous supply of "wipes" made of absorbent wool or butter muslin the antiseptic use for disinfection being a weak solution of creolin or lysol.

The patient was touched by the hands of her attendants as little as possible. Post-partum douching was never practised, except in cases where the uterus had been entered either by instruments or the hand.

Personally, I used gloves whenever interference became necessary, though I do not think that this was the custom of my predecessors. In the Lock Hospital one learnt to avoid all possible risk of cutting one's hands, and any abrasions were carefully sought for and painted with flexile collodion.

Immediately on the completion of the third stage of labour a drachm of the liquid extract of ergot was given to the patient, followed by a similar dose in thirty minutes, after which, on every third hour for three occasions, half a drachm of this preparation was administered. In addition to this I invariably prescribed a bottle of quinine, which lasted till the sixth day. Usually, on the tenth day the woman was transferred back to the care of her visiting surgeon and resumed her former specific treatment.

Concerning the infants, the main anxiety in their case was to prevent their eyes becoming infected. For this purpose the nurse stood ready with "wipes" for their ablution, and the moment they appeared at the vulva they were washed till clean. Silver nitrate solution was not used, and whilst I was in the hospital no case of ophthalmia neonatorum occurred, though subsequently to their birth some children developed a more or less severe conjunctivitis from which they made good recoveries. These may be considered, perhaps, as accidental occurrences, caused by any one of the numerous and obvious dangers infants are exposed to in such a hospital. No sooner was a baby born than every woman in the ward and building seemed moved by a common desire to nurse it, and in spite of the vigilance of the staff they no doubt sometimes succeeded in doing so. The most frequent sequelæ of gonorrhœa in a pregnant woman in my experience was suppurative mastitis, sometimes of enormous extent.

Pyosalpinx is stated by German gynæcologists to be caused by gonorrhœa in a proportion of one-fifth of all cases of this condition. Of 2,078 cases, 279 were diagnosed on clinical data to be in consequence of gonorrhœa, and where accurate bacteriological investigation was undertaken, Wertheim found that 76 cases, out of a number of 376 of pyosalpinx, were due to gonococci bacilli (Hart and Barbour, "Encyclopædia Medica," vol. iv.). Yet it is a remarkable fact that practically no case of pyosalpinx appears amongst the records of the Lock Hospital returns. It was the opinion of the visiting surgeons (1903) that pyosalpinx was rather an accidental sequence of gonorrhœa, due to injudicious douching, the use of the uterine sound, or to labour occurring after a recent gonorrhœa.

Dr. F. J. M'Cann, physician, Samaritan Free Hospital, London, in his contribution on gonorrhœal infection in the "Encyclopædia Medica," appears to me to share somewhat similar views.

THE OUT-PATIENTS' ROOM.

ROYAL FREE HOSPITAL.

Case of Villous Papilloma of the Bladder with Symptoms Referred to the Hip-Joint.

By JOSEPH CUNNING, M.B., F.R.C.S.

A MAN, æt. 52, came to the out-patient room with pain which he referred to the hip-joint. He had already been seen a week before, when he was found to have ankylosis of the left hip-joint, some shortening and also considerable enlargement and prominence of the great trochanter. He said the trouble in the hip had been going on for about a year. The symptoms had all been attributed to the hip-joint. He now brought up with him a sample of his water, which it was easy to see was composed of nearly pure blood. Inquiries showed that the bleeding had been going on at intervals for nearly two years, and the pain which he had referred to the hip was always exaggerated at the time of the bleeding, and then was of the character of renal colic. He had been quite free from bleeding at intervals of from one to two months. There had been no frequency of micturition, and there was no enlargement or tenderness of the kidney. A diagnosis of villous papilloma of the bladder was made because, as Mr. Cunning pointed out: (1) Cases of intermittent profuse hæmaturia were most commonly due to growths in the bladder; profuse hæmorrhage from the kidney was very much less common; (2) the growth was almost certainly a villous papilloma, because of its slow progress; and (3) the fact that the patient returns to the normal state and the hæmaturia entirely ceases for one to two months was an important point of distinction between villous papilloma and a malignant growth; the symptoms of bleeding

and pain in the latter never entirely disappear; (4) no infiltration could be felt at the base of the bladder *per rectum* or bimanually; (5) the growth was probably situated at the left ureteric orifice, for villous growths rarely produce pain apart from cystitis, unless at one of the orifices; if at the ureteric orifice they produce symptoms resembling those of stone in the bladder. The only way to satisfactorily clear up a case of this kind, Mr. Cunning said, was to examine with the cystoscope. As the bleeding had practically ceased at the time a cystoscopic examination was carried out. The urethra having been cocainised, the bladder was washed out till the fluid came back perfectly clear. On examination with the cystoscope the papilloma could be distinctly seen looking like a mass of pink waving seaweed, and, as suspected, growing from the neighbourhood of the left ureteric orifice. There were no secondary masses of growth in other parts of the bladder. A suprapubic operation was recommended, and stress was laid on the importance of removing a portion of the submucous tissue with the papilloma in order to avoid the possibility of recurrence. Mr. Cunning pointed out that it was lucky that this patient had brought his urine on his second visit, as when first seen he had given no urinary symptoms but only complained of the hip, which was undoubtedly diseased but the disease there had then really worked its own cure. With regard to the prognosis, Mr. Cunning thought that in men over 40 although these cases microscopically presented the appearance of innocent growths, yet there was a very marked tendency to recurrence in other parts of the bladder, so that operation was very much less satisfactory than in younger people. With multiple papillomata the patient was bound to get cystitis and extension to the kidneys, so that he ends in suppurative pyelo-nephritis. The removal of a part of the submucous tissue he had before alluded to gave, he considered, in young patients a good chance of non-recurrence, but in an older man, even with this precaution, the chances of non-recurrence would be far less. In cases which could not be operated on because of the extensive character of the growths, the best plan to adopt, he thought, was to cocainise the bladder, and then inject a 1 per cent. solution of resorcin; this had the effect of shrivelling the papillomatous tendrils which the patient subsequently passes in his urine.

OPERATING THEATRES.

ST. THOMAS'S HOSPITAL.

DUCT CANCER OF THE BREAST IN A MALE.—Mr. H. BETHAM ROBINSON operated on a stout man, æt. 64, who had been admitted on June 11th, 1906, with a tumour in the left breast. The patient gave the following history: Nothing abnormal had been noticed until last Christmas, when on stooping down some inconvenience was experienced owing to the lump in the breast. At this time the lump itself was said to have been the size of an orange; there had been no pain before or since, and he had complained of no special inconvenience except from the main feature of the disease, namely, exudation from the nipple. The man said he had lost flesh during these last six months, and had felt languid and worried. On admission both breasts were extremely well developed, but this was only in relation with the general superfluity of fat. The left breast was unduly prominent in the nipple region, and on examination there was to be felt a well-marked lump occupying the upper and outer quadrant of the gland; this lump was not larger than an orange, and over it the skin was free and the mass itself quite movable on the deep structures. It was definitely cystic, and on pressure a dirty brown fluid came from the nipple at its upper part; the nipple itself appeared a little drawn in at the upper part. There was some indefinite fulness in the left axilla, but it was impossible to distinguish individual glands owing to the large amount of fat. His general condition of health beyond this was quite satisfactory. The diagnosis of the case was a cystic tumour arising from the larger ducts in the nipple region, because of the characteristic discharge and the relationship of the growth to the breast structures. Whether this growth was innocent or malignant it was, Mr. Robinson said, impossible to decide before operation, but he felt convinced that it would prove malignant because of its size, the indefinite fulness in the axilla, which probably indicated secondary glands and the evident loss of flesh. On June 13th, the breast was freely removed and the axilla entirely cleared of its fat. This was shown to be essential by the presence of several discreet glands scattered through the mass of fat. Section of the tumour showed several cysts, each about the size of a walnut, and in nearly all of them were intra-cystic growths of a firm bossy character. There was also evidence that the growth involved the wall of the cysts and surrounding connective tissue. The axillary glands on section gave evidence of probable secondary deposits. The diagnosis expressed as to the probable malignancy of the growth was supported and has been confirmed since, on histological examination, the nature of the tumour being duct cancer, composed of calumnar and cubical epithelium. Mr. Robinson said that of course tumours in the male breast were not frequently met with, but this particular form of growth in a man was especially rare. This discharge from the nipple was, he pointed out, the most characteristic feature of swellings arising in the ducts, but when the growth was purely local it was almost impossible to say before histological examination whether it was simple or malignant. In his experience the most innocent-looking papillary tumour in the majority of cases gave histological evidence of malignancy, so much so that he would be inclined to regard all of them as malignant, and accordingly would advise a very guarded prognosis to be given in such cases. Fortunately, he said, the standard of malignancy in this form of growth was decidedly lower than in common spheroidal-celled breast tumours, so that free removal offered a more hopeful future to the sufferer. Although such growths in the ducts of a man's breast were rare, yet he thought that, on the supposition that the ducts in the male breasts would be more developed than the glandular tissue proper, these growths, in a search perhaps through all the reported cases, might be shown to be proportionately greater than was at present considered. The wound healed by first intention.

ITALIAN HOSPITAL IN LONDON.

A CASE OF SARCOMA OF THE TONGUE.—Mr. LENTHAL CHEATLE operated on a woman, æt. 52, who presented a round, defined solid swelling in the right side of the tongue at about the junction of the anterior two thirds with the posterior third under the mucous membrane. No lymphatic glands were enlarged, and the surface of the tongue was normal. The growth had been noticed six weeks ago. An encapsuled tumour was easily removed from the submucous and inter-muscular tissue, without hæmorrhage, by means of a longitudinal incision over the swelling of about one and half-inches in length. The wound was sewn up with catgut.

Mr. Cheatle pointed out that the mouth had been prepared beforehand with a view of preventing sepsis. Her teeth had been well scrubbed and old teeth stumps

removed. The tumour on being incised appeared of uniform consistence and was, Mr. Cheatle said, either a fibroma or a sarcoma. A section was made. There was no glandular tissue. It was composed of spindle cells with large nuclei; the blood vessels were not highly organised, and although there was a history of rapid growth, the structure of the tumour suggested a not very malignant form of sarcoma; but he thought it was wise not to lay too great stress upon the microscopical appearances when the degree of malignancy was in question. Although the tumour had been widely removed, the case would, he remarked, be carefully watched in the future. He asserted that sarcoma was a rare disease of the tongue. He did not know exactly the number of examples recorded, but he believed it would not amount to forty well authenticated cases.

SPECIAL REPORTS.

THE PUBLIC HEALTH CONGRESS AT CORK.

THE opening meeting of the Congress of the Royal Institute of Public Health was held in the Queen's College, Cork, on the 27th ult., the City High Sheriff, Mr. R. H. Beamish, presiding.

Professor Smith, having invested President Windle with the President's badge of office, the latter delivered his inaugural address.

Having welcomed the Congress to Cork, he said they had come to a country where matters of public health were, perhaps, as badly in need of public interest and attention as in any country in the world, for no other country presented such great possibilities of happiness and health and no other country presented a similar picture of misfortune and decay. If there was a country in the world which should be healthy, happy, and prosperous, filled with strong men and women, lusty children, and smiling homesteads, it was this land. In respect to health, they were far, very far, from being where they should be. On the contrary, they were the prey of evils which seem to be increasing rather than diminishing as the years rolled by. Year by year the death-rate from consumption had been steadily declining in England and in Scotland, and as steadily increasing in this country. Side by side with this advancing rate of mortality from tubercle, there had been an alarming increase in the number of the insane. Of every 10,000 persons in Ireland, 52·6 were registered as lunatics or idiots. It was, unfortunately, only too true that lunacy was on the increase in England and Wales also, but the actual figure there was 34·71 per 10.000. The emigration curse, which year by year drained away the life-blood of our race in the shape of its youngest, its most promising, its most valuable members, had, in his opinion, a great deal to do with that. It had been said that what was happening here was a survival of the unfittest. He would like to ask the local authorities whether they were doing all that was in their power to stem the tide of disease? Were they taking all the advantages that they could from the Public Health Acts, from the Housing Acts, from the other enactments which have from time to time been passed with the view of improving the health of those whom they had been elected to watch over? Were they making use of the provisions for the notification of disease, and particularly of the tuberculosis disease, from whose ravages we are so severely suffering? Were they helping the medical profession in its struggle against the enemy by appointing bacteriologists in the towns and in the counties? But it was not only public authorities who had a responsibility in this matter. It was one in which the general public was deeply interested, and in which it also had its part to play, if the country was to come safely through this present period of trial. And he would, therefore, like to ask the members of the general public whether they were keeping an eye on their Public Health Committees, with a view of seeing whether those Committees were doing all that they could to preserve the public health? Were they trying to help those associations which were doing their best to bring about a better state of affairs in connection with the health of themselves and of their neighbours? Were they doing anything to promote temperance or a better housing of the poor?

On the motion of Alderman Dale, seconded by Mr. Stanley Harrington, a vote of thanks was passed to Dr. Windle for his address.

Speeches in support of the motion were made by the Mayor of Folkestone, the Mayor of Birkenhead, Sir John D. Littlejohn, M.D.; the High Sheriff of Limerick, Sir Charles Cameron.

On the following day the Congress met in four sections—(1) Preventive Medicine, (2) Child Study and School Hygiene, (3) Engineering and Architecture, (4) Bacteriology and Chemistry.

Among those who took part in the various discussions were Dr. Hope, of Liverpool; Dr. McWattee, of Dublin; Dr. Marsden, of Birkenhead; Dr. Donovan, of Cork; Rev. O. J. Hickey, of Waterford; Mr. Wall, Mayor of Birkenhead; Judge Gibson, of Edinburgh; Dr. Browne, of Cork; Dr. Corby, of Cork; Mr. Wallis-Hore, of Cork; and Mr. J. Kelly, of Dublin.

CENTRAL MIDWIVES BOARD.

MEETING HELD JUNE 28TH, 1906.

The President, Dr. CHAMPNEYS, in the Chair.

AT the beginning of the meeting the Secretary read a letter from the Clerk of the L.C.C., saying that Dr. Wanklyn had reported the Whitechapel Infirmary structurally unfit for a training school for midwives.

Upon the question of examinations being held in Welsh for Welsh midwives, it was agreed that Dr. Walford, M.O.H., for Cardiff, be asked whether in his opinion the difficulty would be met by the presence of an interpreter at the Oral Examination.

A letter from Dr. Gordon, Hon. Sec., Salisbury Division B.M. Association, enclosing copy of a resolution as to the form to be filled in for sending for medical aid, was read and answer was returned that the draft copy of Rules now under consideration by the Privy Council met in part the objections raised.

Mr. WARD COUSINS thought midwives should certainly be instructed that the form did not entail the compulsory attendance of a medical man, and again he would ask who was to pay the fee for such attendance.

The PRESIDENT considered that the midwife made herself responsible for the fee by sending for him.

A letter was then read from Dr. Walford, M.O.H., Cardiff, saying he had good reason for believing that a midwife who received pupils had the certificates signed by Dr. D. E. Powell, of Cardiff, though the latter had not personally supervised all the cases for which he signed.

It was arranged that Dr. Powell be asked for an explanation, but

Mr. WARD COUSINS remarked that he could sign under the rules. He knew general practitioners who gave 20 cases to their midwives and then signed certificates though they themselves had not superintended the cases. Such matters ought to receive most serious attention from the Board.

Since the last meeting a Standing Committee had met to consider what answer should be returned to the Privy Council *re* making Dublin an Examining Centre, and at the present meeting it was recommended that the Privy Council be informed that the Board had carefully considered the memorandum handed to the Lord President during a recent visit to Dublin. The Board suggested that as it is now proposed to defray the expenses of an examination in Dublin by a special contribution, the difficulty might be

met by those interested in the matter paying the travelling expenses of candidates to an English centre That the work of the Board being supported by English rates, etc., they could not use it for Irish expenses.

Mr. WARD COUSINS remarked that the Board had no control over midwives practising in Ireland, and

Dr. PARKER YOUNG added that Ireland had in the beginning wanted to keep out of the Act and now found she had made a mistake. It was to be hoped Dublin did not intend raising the money by raising the examination fee, as that was contrary to the Act. They would never succeed in satisfying Ireland, and he did not think it wise to extend the area of examination centres.

Miss PAGET agreed, adding that if Dublin were satisfied Belfast would not be. It would be quite easy for the women to come to Liverpool.

It was finally agreed to send in the answer to the Privy Council and discuss the matter further when further communications were received.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

GERMANY.

Berlin, July 1st, 1906.

AT the Hufeland Society, Hr. Ewald showed preparations from a case of

THROMBOSIS OF THE PORTAL VEIN.

The man. æt. 36, from whom the preparation was taken, went to the Augusta Hospital on April 23rd. Before this he had been a healthy man; whilst a soldier he was said to have had gonorrhœa. For two years he had suffered from pain in the stomach and headaches. Up to April 19th, he had performed his duties as keeper in a prison. Since then he had complained of frequent spasms in the lower part of the abdomen, and on both sides shooting towards the chest. Three or four times a day he had attacks of vomiting of greenish material. These lasted about twenty minutes each time. The cramps came on suddenly and were frequently accompanied by hiccough; the bowels were obstinately confined, but they acted under enemata. He was a powerfully built man, but much reduced. There was no jaundice, very slight glandular swellings, the liver somewhat disturbed, the spleen enormously enlarged and of hard consistence. The stomach contained about 80 ccm. of bile like material, no free hydrochloric acid, but abundant chlorides, and no blood. There was no fever, slight dulness in the lower part of the abdomen. No symptoms of stenosis were present; strong indican reaction in the urine. The general condition and pulse very good. Rectoscopic examination showed a good deal of swelling and softening of the mucous membrane, and some punctiform hæmorrhages. On the third day there were violent pains, and a good deal of hæmorrhagic vomit. Fæces hippocratica. The pulse went up to 156. Ice water washings out and infusion of saline solution. The patient died during the night. The speaker suspected thrombosis of the mesenteric artery, or of the mesenteric veins. Against this view was the absence of ascites, of jaundice, and of blood per rectum. The whole case was opposed to ulcer of the stomach. The autopsy revealed thrombosis of the portal vein. Both stomach and intestines contained a large quantity of blood. That syphilis was a cause of pylophlebitis was an acquisition of recent date. Usually excessive changes in the liver preceded thrombosis of the portal vein.

He also related the case of an elderly woman who died with symptoms of carcinoma of intestine. The autopsy, however, only showed chronic dysentery, and no trace of malignant disease. Cases of chronic dysentery in old people without any demonstrable etiology were not so rare.

Hr. Grawitz confirmed the statement that chronic inflammations of the bowels in old people were frequent and difficult to diagnose during life. They could be more correctly described as chronic colitis originally di htheritic, later necrotic. He always had the impression that the condition was caused by mercury.

Hr. Ewald then described a case of

LEUCÆMIA WITHOUT LEUCÆMIC BLOOD.

The powerful but much emaciated man was in the hospital six days. There was no sternal pain. There was a systolic murmur over the heart. There were no glandular swellings, and the spleen was not tender. The liver was slightly enlarged, but not particularly tender. The motions contained no blood, but there was hæmorrhage into the retina. There were no tubercle bacilli. Death took place after a rigor and rise of temperature. Examinations of the blood were made almost daily, but without discovering anything special. The spleen was considerably enlarged. There were circumscribed hæmorrhages in the stomach. The speaker went through the various diseases that might come into question in the case, and decided for the clinical diagnosis "leucæmia," as the blood might undergo changes under the influence of intercurrent diseases.

At the meeting of the Verein f. Schulgesundheitspflege, Hr. Neufert spoke on so-called

FOREST SCHOOLS (WALDSCHULEN).

In a lengthy address, the substance of which is as follows, he said that children suffering from chronic ailments, unfitted for regular attendance at school, should be separated as much as possible from the other children in schools in which their faulty bodily and mental developments would be taken into consideration. A school in the woods with shortened hours of instruction, with sufficient provision for recreation, as in the Charlottenburg Waldschule, was suitable. The hygienic aim of wood-schools was the strengthening and recovery of chronically unhealthy children by simple hygienic and medicinal means—residence in the forest and copious sunlight, strengthening diet, and suitable bathing. The pedagogic aim was to bring the children forward with their education as quickly as their bodily and mental condition allowed, so that on their return to their ordinary schools they would be able to keep pace with their companions in the classes as before. In the class grouping in the forest schools only teaching and hygienic points were to be considered; the sexes, therefore, need not be separated and no dogma should be taught. It was desirable to prolong the period of the forest schools over the milder winter months. For a proportion of the children needing the forest school, a sanatorium attached to it was desirable, in which children could be cared for night as well as day.

Prof. Baginsky said that chronically diseased children belonged to recuperative places and not to schools. The value of the forest school was extraordinary if only children that were not too ill were admitted. Forest health resorts and forest schools must be kept apart.

Hr. Lennhoff said the kind of institution to be erected, Waldschule or convalescent institution, would depend on the local conditions. Just so much instruction should be given as would prevent children from falling back. The forest school as a school for the less unhealthy children might have a future before it.

Hr. Neufert was of opinion that the two kinds of institution might be erected near together; the main object of the one would be the treatment of disease, that of the other the instruction of unhealthy children.

AUSTRIA.

Vienna, July 1st, 1906.

DEXIOCARDIA AND CYANOSIS.

HOCHSINGER showed a case of right-sided cardia in an infant, æt. 6 months, with peculiar symptoms. This child was the sixth by healthy parents. When born, the whole body was of a damson blue colour and asphyxiated. With artificial breathing, rubbing, &c., the infant was restored to life, but has always suffered from shortness of breath and cough. Up to fourteen days ago the child took its food well and in other respects was normal, but bronchitis and nasal

catarrh brought it to hospital. When the child is at rest the cyanosis is absent, but immediately it awakes the cyanosis appears on fingers, feet, face, and arms. When it cries the whole body is as dark-coloured as a damson.

The pulse is 150—160, tonometer pressure 90 to 100. The cardia is wholly in the right side of the thorax while liver and spleen are in their normal positions, which is unusual in transposition of the heart. It is therefore a simple isolated dexiocardia. The cardiac sounds are clear and healthy when the child is quiet and at rest, but as soon as it begins to cry or is fretful a hissing systolic murmur appears, more audible in the precordial region and apex than at the base. The second tone is louder than the first. Behind the right shoulder the same hissing sound can be heard, and greatest at the lowest part. The trouble seems to lie in the venous apparatus or in the wall of one of the ventricles, or it may be due to a stenosis of one of the arterial ostia.

The Röntgen rays revealed a wider area in breadth, and above, between the second and third intercostal space, the pulmonary artery formed a wide arch as it distended. In the second intercostal space the opening Botalli seemed to be closed.

This widening of the pulmonary artery seemed to be the cause of the increased diastolic sound heard over the sternum. The diagnosis was given as a defect in the ventricular septum with dilatation of the pulmonary artery in a congenital dexiocardia.

RACHITIS LARDA.

Drey showed a case of a seven years' child who was pale, fairly well nourished, and well developed. The girl was the eldest of six sisters, who lived in a house with two rooms badly ventilated. Four months ago the mother observed that the girl walked strangely with bent legs, and two months later she complained of great pain and could not walk to school. It appears that when æt. 2 she was taken to Kassowitz' Clinic, where she was treated for rachitis and according to the mother's story no deformity of bone then existed; the only reason for taking the child there was inability to walk. After the use of six bottles of phosphated cod liver oil, the child quite recovered. No other disease was recorded in its history.

On admission the bones of the head and face were normal, the chest was small and compressed antro-posteriorly. The epiphysis of the ribs were thickened, the spinal column straight, pressure on the symphysis pubis very tender, but most striking of all was the thickening of the distal epiphysis of the radius and ulna with a distinct rachitic hand. The lower extremities had the same distal thickening of the tibia and fibula, with a distinct bending of the former, or crura vara. The abduction of the right leg was limited, and gave great pain, a distinct symptom of initial coxa vara.

Drey agreed with Kassowitz' classification of two forms of rachitis tarda—(*a*) cases of long-standing rachitis gravis with deformity, probably delayed till the second dentition period; (*b*) cases appearing in the adolescent period as those recorded by Bokai and Marsden, which have been designated rachitis adolescentium.

A FOURTEENTH CENTURY PRESCRIPTION.

Dr. Senfeld, of Vienna, has been turning out the alcoves of the University Library in search of Dr. Paul de Sorbait's wit and humour. The following prescription is recorded as the result of a consultation of two leading men of the time:—

R Tabellionem (Notary), j.;
Testes (Witnesses), vij;
Fossores cum liqoribus (Gravediggers), ij;
Vespillonum (Pall-bearers), paria ij.

Adde sacerdotem cum aqua et oleo benedictis, quantum satis et dispone domui tuae: quia morieris.

P.S.

R.F.

HUNGARY.

Budapest, July 1st, 1906.

AT the recent meeting of the Budapest Interhospital Association, Dr. Schmidt read a paper on

PROTECTION AGAINST SUNSTROKE,

in which he dealt with the protection of the tissues of the head, and referred to the various articles generally worn to ward off the direct rays of the sun. The entire skull, inclusive of a thin layer of hairs, he remarked, is permeable for thermic as well as actinic rays. Cerebral tissue is relatively less diathermous, so that the cortex absorbs most of the rays. Anæmic blood is much more diathermous than normal blood, and this explains why patients with malaria are more subject to sunstroke. It is hardly probable that the ultra violet rays cause sunstroke; it seems more likely that the heat and light producing rays are responsible. White skin allows these rays to pass through about twice as readily as negro skin. Straw hats and white caps without lining are a very poor protection, the so-called tropical helmet being a much better safeguard. The value of the various cloths used in the tropics had not yet been decided.

Dr. Donath referred in a paper to some

ELEMENTS OF METABOLISM IN EPILEPSY.

Impressed with the contradictory results reported from analyses of the urine of epileptics he undertook the study of urine during a period of from one and a half to two months in each of five epileptic patients; examinations of a given quantity of the urine eliminated during twenty-four hours being made daily. The diet was so regulated in each case as to establish metabolic equilibrium.

Dr. Donath tabulates his findings as follows: (1) The quantity of urine was normal in the majority of cases; (2) the colour varied from straw-colour to golden; (3) the specific gravity was always high, even when an increased quantity of urine was eliminated; (4) acidity was normal, or slightly below normal; (5) phosphoric acid varied within normal limits; (6) the amount of urea corresponded to that considered as medium by authors in general, but it was less than that which should have been eliminated, with the diet given; (7) the quantity of chlorides was generally above the normal, though at times it reached the normal. No connection was apparent between the variations in these elements of the urine and the occurrence of epileptic seizures. An increase in indican was always seen the day following a seizure. Not the faintest trace of albumin was found after an epileptic seizure, whether this was repeated or not.

Dr. Jordan discussed the question of

TARDY HEREDITARY SYPHILIS.

The symptoms of hereditary (tardy) syphilis are generally manifest at birth or appear within the first two or three months. They are the same as in the acquired disease of adults, but differ in their sequence, and in the regularity of their appearance. In tardy hereditary syphilis, tertiary signs may make appearance as late as the twentieth year. Drl Jordan divides these cases into two classes, viz., where syphilitic manifestations were present in earliest youth and had disappeared with proper treatment, and, secondly, where these late signs gave the first clue of infection. This class is not recognised by many syphilographers, but two undoubted cases are cited. It generally appears as a bilateral affection of the knees, either an arthralgia, a simple chronic hydrops, or a deforming arthritis. It is often extremely difficult to make a diagnosis, but if no direct history is present an antiluetic treatment should be resorted to in all symmetrical cases which resist other measures, especially if there are marked fluctuations in the course. Often the presence of a parenchymatous keratitis will assist the diagnosis.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

SIR ALEXANDER RUSSELL SIMPSON.

EMERITUS PROFESSOR SIMPSON'S long and distinguished career has been crowned by the well-merited honour of knighthood, and all his old students must have felt, when they read his name in the list of recipients of the King's Birthday honours, that few have more thoroughly deserved recognition than he. Sir Alexander Simpson retired from the chair of midwifery in the University of Edinburgh a year ago, after having occupied it for thirty-four years. A native of Bathgate, he acted in his younger days as assistant to Goodser and to his uncle, Sir James Simpson, whom he afterwards succeeded. He was an unrivalled operator in gynæcology, and has an encyclopædic knowledge of the literature of his subject. In congratulating Professor Simpson on his well-earned distinction, we may also be allowed to express the hope that he may long be spared to enjoy the leisure and recreation to which his labours in science and education so justly entitle him.

WOMEN GRADUATES AND THE PARLIAMENTARY FRANCHISE.—Counsel was heard on June 27th in the action brought by Miss Margaret Nairn, M.A., and other graduates, against the University Courts of Edinburgh and St. Andrews for declarator that the pursuers. being on the register of the General Council of the University of Edinburgh, were entitled to receive voting papers on the occasion of any future election for a member of Parliament to represent the two Universities. After hearing Counsel, Lord Salvesen made avizandum of the case.

PROFESSOR MCKENDRICK'S VALEDICTORY ADDRESS.—Professor McKendrick delivered a farewell address to the students on June 29th, in which he told his audience the story of how he came to be a physiologist, and sketched the progress of the science during the thirty-five years he has occupied the chair. Even before he studied medicine he had been attracted by the natural sciences, especially physiology. In Edinburgh, the influence of John Goodser intensified his desire to devote himself to the subject, but after graduation he saw no hope of reaching the fairyland of science, and had been compelled to practise in hospitals and dispensaries. In 1868, while resident surgeon in a little hospital in Port William, Hughes Bennett came to see a patient dying in a shooting lodge in Glencoe; he met him there, and the result of the interview was that Bennett took him as assistant in succession to Professor Rutherford, who had just been appointed to King's College. His physiological career thus begun, in due time he returned to Glasgow in 1876, and there the happiest days of his life had been spent. Turning to the progress which physiology had made, it was probable that microscopy had now nearly approached perfection, and it was doubtful whether much more progress would be made along the path of histology. Turning to vivisection, he could not understand how its value could be denied—witness Pawlow's researches—yet he thought its educational importance had been overestimated, and that only very few experiments need be demonstrated to students. In the past too much of the student's time had been taken up on difficult experimental work on the physiology of nerve and muscle, and on relatively unimportant matters of electro-physiology, such as a demonstration of Pfluger's law of contraction and electrotonus. The two departments of physiology in which the greatest advances had been made were our knowledge of nerve paths in the central nervous system, and the subject of internal secretions. The influence of this increase in knowledge was seen in yearly increasing accuracy in the diagnosis of nervous diseases, and in the new light thrown on the functions of special organs and the general economy of the body. There could be little doubt that the progress of the next few decades will be made along the line of physiological chemistry; this was confessedly the most difficult of all branches of investigation. It demanded that the writer should be a trained chemist as well as physiologist, that he should have a thorough grasp of organic chemistry and physics. To make an ideal physiological chemist we would begin with a Roscoe, link to him an Emil Fischer, and weld with these a Kelvin and a Pawlow. When we get a grasp of the chemical processes of the cell we will be near an understanding of the phenomena of life. Professor McKendrick concluded by expressing his satisfaction at the provision of laboratories for experimental psychology—the link between physiology and psychology, and said: "Now I lay down my arms, not as a tired or beaten soldier, but as one who has served his time and wishes to retire in favour of youth and energy and enthusiasm. The evening approaches, and one wishes to have time to work on tasks that are altogether congenial, to meditate on the past, and to search the intellectual horizon with hopeful eyes for the revelations of the future."

ROYAL INFIRMARY, EDINBURGH.—The managers of the Infirmary have under consideration an offer by the Admiralty to transfer to them at a peppercorn rent the Royal Naval Sick quarters at South Queensferry. The buildings are to a large extent new, having been completed only last summer, and are now not required by the Navy, owing to the transference to the south of the training ship "Caledonia." The suggestion is that the buildings might be used as a sanatorium, and that if taken they are to be kept in repair and handed over to the Admiralty at three months' notice if required. The buildings are situated in a healthy part of the county, amid beautiful surroundings. Their distance from Edinburgh will no doubt be a disadvantage, on account of the additional cost this would involve. The matter has been remitted to the House and Medical Committees.

BELFAST.

BRITISH MEDICAL ASSOCIATION.—At the annual meeting of the Ulster branch of the British Medical Association, it was decided to invite the Association to meet in Belfast in 1909 or 1910. The last meeting in Belfast was in 1884, and the last Irish meeting was in Dublin in 1887, so it is quite time that the Association visited Ireland again. The formal invitation will not be given till next year when the proposed president will have to be named, but the general arrangements will no doubt be informally discussed during the year. There is evidently a desire to make the meeting, if held in Belfast, as great a success as possible.

THE RECENT EPIDEMICS AT NEWTOWNARDS.—Attention was called several times last year in this column to the epidemics from which the little town of Newtownards in County Down was suffering. The outcome of these epidemics promises to lead to a better state of things in the sanitation and water supply of the town, which were notoriously deficient. A bill is now before Parliament to authorise the Newtownards Urban District Council to remedy these defects, and the statement made by Mr. Macassey, representing the promoters, showed how badly needed the proposed improvements are. In the town, which has 9,000 inhabitants, there were last year 48 cases of scarlatina, 58 of typhoid, 150 of measles, and many of diphtheria and typhus. Dr. Jamison, the medical officer of health, gave a horrible picture of the state of many houses as regards sanitary matters, and said that for fifteen years he had been urging the necessity of improvement.

QUEEN'S COLLEGE.—On Saturday afternoon, the 30th ult., the College received a visit from its generous benefactor, Sir Donald Currie. It was owing to his munificent gift of £20,000 that the Better Equipment Fund was able to reach the grand total of £70,000, and the fruit of this fund is already visible in the greater efficiency of many of the departments. It was fitting, therefore that on the occasion of his visit to Belfast to receive the freedom of the City, the College should also do Sir Donald Currie honour. He received addresses from the College faculty and from

the students, and in his reply he made a further offer of £1,250 if the students could raise the remainder of a sum of £5,000 for the purchase of athletic grounds.

LETTERS TO THE EDITOR.

HYGIENIC MEASURES AGAINST SYPHILIS.

SIR,—If syphilis be preventable, in God's name let it be prevented. As medical men, we are surely justified in using any conceivable means that will compass so desirable an end. But, of all human measures, we as a nation have rejected the most powerful and direct—namely, that of a stringent Contagious Diseases Act. Owing to the sentimental clamour of a knot of faddists the extermination of syphilis has been postponed by half a century or more. Meanwhile the chief burden of that terrible malady is borne by helpless and innocent women and children, and the springs of public charity are depleted in the attempt to remedy the havoc wrought by noisy sentimentalism.

I am, Sir, yours truly,

A SEAPORT HOSPITAL SURGEON.

"FOR FOES WITHIN ONLY."

SIR,—With reference to the paragraph under above heading on the front page of your issue of June 27th, may I be permitted, as a medical man who has borne the heat and burden of the day, to make a few remarks? Never was a truer word spoken than that which attributes the present well-nigh hopeless plight of the medical profession to the fact that "the disciplinary powers of the General Medical Council are mainly domestic." Think for a moment what a revolution would overtake the medical world were the Council to turn its weapons against the enemy without as well as against offenders within the house. At one blow the whole vast field of illegal medical practice would be reduced to a footing of insecurity, and much of it would disappear forthwith. In other words, legitimate medical practitioners would come into their kingdom, which is at present harried and plundered on every side by quacks and charlatans. So far as we are concerned, I have no hesitation in affirming that one clever scoundrel practising bonesetting or some other form of irregular medical practice will cause more monetary loss to the profession than a hundred petty defaulters of our own cloth, who are too often driven into peccadilloes by the degrading poverty of the learned profession which they have embraced.

Sir, in my humble opinion you are entitled to the warmest thanks of the profession for the outspoken way in which you have not only fearlessly demonstrated the evil but also pointed out the remedy. The present constitution of the General Medical Council I regard as a scandalous anomaly. They are, in effect. an assemblage of aristocrats nominated to defend the privileges of ancient and effete corporations. Their attitude towards the main body of the profession is one of lofty arrogance and contempt. Let us agitate as a self-respecting and much-tried profession for a General Medical Council that shall be elected by ourselves. In that, I firmly believe, lies our only hope for the future.

I am, Sir, yours truly,

A VETERAN.

OUR HOSPITALS.

SIR,—Your correspondent, "R. L." seems to grasp half the truth of a very serious situation. Most general practitioners will agree with him in the assertion that serious injury has been done to them throughout the country by the opening of hospitals to patients who formerly paid their fees. That is the evil arising from indiscriminate charity that forms the greater part of the standing wrong known as "hospital abuse." However, "R.L." does not appear to be doing much to set matters straight when he says: "The reform that must be made in our hospitals is evidently that they must let the patients supply the funds required for their support, and not let them be treated as simple recipients for charity." In other words, he would still let the persons attend hospital, although they have no right to go thither, the only difference being that he would make them pay for their accommodation. That may be a plain and simple reform to the mind of your correspondent, but I confess its logic is not clear to me. So far from the payment of a tax remedying the original offence, it would, to my thinking, increase it a hundredfold. First, it would still the conscience of the mean appropriator of charitable funds. Secondly, it would divert still more money from the income of the general practitioner. Thirdly, it would put more money into the pockets of the hospital charities wherewith to carry on their nefarious campaign against the general practitioner. Words of bitterness these may seem, but they are born of experience.

I am, Sir, yours truly,

AN EAST END PRACTITIONER.

London, E., June 30th, 1906.

OBITUARY.

DR. JOHN WINTER DRYLAND, J.P., OF KETTERING.

DR. JOHN WINTER DRYLAND, J.P., who, since 1859, had been in practice at Kettering, died on Sunday week, June 24th, after a long illness due to heart disease and dropsy. In 1859 Dr. Dryland acquired the practice of the late Mr. Sanderson Wyman, of Kettering, which he gradually developed into one of great extent. In conducting this large practice during late years Dr. Dryland had the able assistance especially in the operative and surgical side, of his son, Dr. Leslie Dryland. Dr. Dryland was born at Newbury, in Berkshire, and began his professional career as an apprentice to Mr. Winter, of Brighton, in 1849, and from thence he passed to Guy's Hospital, where he studied with much diligence, and on leaving Guy's he filled for some time the post of Resident Medical Officer at the Reading Dispensary. At Kettering Dr. Dryland was for many years Health Officer for the town, which had grown rapidly and largely during his residence there. He took great interest in the establishment of the new hospital, to which his son was appointed surgeon, in conjunction with Mr. Roughton, of Kettering.

THOMAS SIBLEY STOTT, M.R.C.S.ENG., L.R.C.P.

WE regret to announce the death of Mr. Thomas Sibley Stott, director of the Animal Vaccine Establishment of the Local Government Board, which occurred on the 24th ult., at his residence in Highgate Road, in his sixty-fourth year. Mr. Stott, who studied at St. Bartholomew's, qualified as M.R.C.S. England, in 1863, and L.R.C.P. and L.S.A. in 1864. Before being appointed director of the Animal Vaccine Establishment he was assistant director under Dr. R. Corry.

HECTOR ALLAN, M.B.,C.M. ABERDEEN.

WHALEY BRIDGE was last week shocked at the sudden death of Dr. Hector Allan, which occurred on the 27th ult. He had resided and practised in Whaley Bridge 32 years, was surgeon-captain in the 2nd V.B. Sherwood Foresters, Notts. and Derby Regiments, and held the long-service medal. He was Medical Officer of Health for the Urban District Council, and public Vaccinator for the district. In politics he was a Liberal. His medical education was conducted at the University of Aberdeen, where he graduated M.B., C.M., in 1870. His death is a great loss to the neighbourhood.

W. BATES RAMSDEN, M.B.,CH.B.VICT., B.Sc.

THE death occurred last week under peculiarly pathetic circumstances, of Mr. William Ramsden. On Friday last, just as he was about to begin his lecture at the Public Health Laboratory, he suddenly fell down dead. Deceased had his medical education at Owens College, Manchester, where he passed a most distinguished career, and took the M.B. with honours in 1903. His death at the early age of 29 cuts short a life full of brilliant promise, as it was already distinguished with early achievement.

MEDICAL NEWS IN BRIEF.

Birthday Honours.

IN the list of new baronets is to be found the name of Christopher Nixon, of Dublin. Sir Christopher was educated in Trinity College, in the Cecilia Street School of Medicine, and in Paris. He has held the Chair of Anatomy and Physiology, is Professor of Medicine at the Catholic University School of Medicine, an ex-President of the Royal College of Physicians, Ireland; member of the General Medical Council, Hon. Fellow of the British Institute of Public Health, a member of the Senate of the Royal University of Ireland, and senior physician to the Mater Misericordiæ Hospital. Sir Christopher was the first President of the Royal Veterinary College, Ireland, an institution which he took an active part in founding. He is the author of several medical treatises, among them being a "Handbook of Hospital Practice and Physical Diagnosis," and various papers on diseases of the heart and the nervous system.

Epsom Medical College.

AT the annual meeting of the Governors of Epsom College, on Thursday last, Sir Constantine Holman, M.D., presiding, the Council presented a report as to the work of the past year, showing that the college gives gratuitously an education of the highest class to 50 necessitous sons of medical men, and provides pensions of £30 a year for 50 medical men, or the widows of those deceased, at a cost of £6,000 yearly. There were now 50 foundation scholars, 10 council exhibitioners, 142 other boarders, 36 boarders in masters' houses, and 16 day boys, making a total of 254. The names of seven successful candidates as pensioners were announced. Out of 30 candidates, four had been successful in obtaining foundation scholarships, viz., Peter M. Braidwood, Arthur Chamberlayne, Robert R. L. Williams, and Geoffrey J. Barrow. The announcement of a donation to the funds by a lady of £5,000 was acknowledged with grateful thanks.

Sir Constantine Holman, on resigning his position of treasurer, which he had occupied for 19 years, said that 51 years ago he took part in the initiation of the college. In 1887, when he became treasurer, there were 191 pupils, as compared with 254 now.

On the motion of Sir William Church (chairman of the Council) the resignation was accepted with regret, and Sir C. Holman's services were warmly acknowledged. He was elected a member of the council, and Mr. Henry Morris was elected treasurer.

Honours to British Research Laboratories.

ALTHOUGH scientific research receives little encouragement in this country, it is gratifying to find that the labours of British scientists are recognised abroad. The Awards to the British Section of the recent Liege Exhibition were distributed at the Mansion House on June 13th, and the following presentations were made:—Wellcome Chemical Research Laboratories, one grand prize, one diploma of honour and two gold medals; Wellcome Physiological Research Laboratories, one grand prize and two gold medals. Medals were also awarded to the respective directors of these institutions.

Women in the Medical Profession.

AT the annual distribution of prizes in connection with the London (Royal Free Hospital) School of Medicine for Women, on Thursday last, under the presidency of Mrs. Garrett-Anderson, M.D., Her Grace the Duchess of Marlborough distributed the prizes and certificates. It was stated that of the large number of students who had passed through the school 43·1 per cent. had taken the London University degree, the highest possible in medical examinations. Only 3·6 per cent. had not qualified at all.

Lady Frances Balfour, who proposed a vote of thanks to the Duchess, made the amusing confession that although for almost a lifetime she had devoted herself to the cause of women doctors she could never bring herself to be attended by one. What, she wondered, would be the result, if Mr. Asquith were told that unless he granted the franchise to them he would be attended by women doctors for the remainder of his life. It might be more effective than storming his citadel.

Dr. Edith Pechey-Phipson, in seconding the proposal, urged her hearers to remember, when they heard of a clever operation or diagnosis by a woman doctor, that they as a sex were classed as lunatics and criminals, a remark that was greeted with cheers and laughter.

West London Hospital Dinner.

THE annual dinner of the West London Hospital and Post-Graduate College was held at the Trocadero Restaurant on June 28th, 1906, under the presidency of Mr. Stephen Paget. After the loyal toasts had been honoured the chairman depicted in glowing terms the future of the hospital, which had now reached the jubilee of its active life. Mr. L. A. Bidwell, Surgeon to the hospital and Dean of the College, in response to the toast of "The Post-Graduate College," stated that he believed last year was almost a record one in the history of any hospital, no less than 226 post-graduates having been enrolled. Constant endeavours were being made to improve the working of the various departments of the college, and he referred with pleasure to the institution of a special section for the study of tropical diseases, which had been placed under the care of Dr. G. C. Low. The health of the chairman was suitably proposed by Dr. G. P. Shuter.

Central Midwives Board.

AT the examinations for certificates of the Central Midwives Board recently concluded, 376 candidates presented themselves, of whom 300 passed; the percentage of failures was 20·2. The women came from all parts of the United Kingdom, almost every training school and maternity hospital being represented; many were also "coached" by private teachers.

Liverpool School of Tropical Medicine.—Anti-malarial Measures in Greece.

THE following telegram has been despatched by the Liverpool School of Tropical Medicine to the King of the Hellenes, Athens, viz.:—"The Liverpool School of Tropical Medicine, at request of the Lake Copais Company, despatched a member of their staff to Greece to investigate malaria there. He reports that malaria is seriously prevalent in Greece, but should be preventable. Sir Alfred Jones, Chairman of the School, of which H.R.H. Princess Christian of Schleswig-Holstein is President) asks whether His Majesty will authorise the School to initiate a movement in England for the prevention of malaria in Greece to co-operate with the Grecian Anti-malarial League of which His Majesty is Patron."

Experiments on Living Animals.

IN the House of Commons last week, Mr. G. Greenwood (L. Peterborough) asked the Home Secretary if his attention had been called to the fact that the recently issued Return of Experiments on Living Animals for the year 1905 shows an increase of no less than 5,373 of such experiments, as compared with the return for 1904, whether he knew any reason to

account for this increase, and whether he could now say when the Commission to inquire into the matter of vivisection would be appointed, and what the terms of reference to this Commission would be.

Mr. Gladstone (Home Secretary).—My hon. friend will see from the return that nearly the whole of the increase in the number of experiments—5,083 out of a total 5,373—is accounted for by the additional inoculations, hypodermic injections, and feeding experiments which have been made. The increase is due to the greater importance attached to biological tests in practical medicine, and to the greater number of these experiments which are performed on behalf of local and other public authorities. With regard to the composition and terms of reference of the proposed Royal Commission, I hope to be able to make an announcement very shortly.

Vital Statistics

ACCORDING to official returns of the Registrar-General, the deaths registered last week in the eighty great towns of the United Kingdom corresponded to an annual rate of 14·2 per 1000 of their aggregate population, which is estimated at 17,732,694 persons in the middle of this year. Measured by last week's mortality, the highest annual death-rates per 1000 living, were :—From *all causes*, 18·1 in Warrington, 18·2 in Middlesbrough, 18·3 in Bradford, 19 in Belfast, 19·5 in Merthyr Tydfil, 19·8 in Burnley, 20·1 in Dublin, and 2·28 in Hanley; from *measles*, 1·4 in Bradford, 1·6 in Wallasey, 2·2 in Manchester and in Salford, 2·9 in Halifax, and 3·0 in Burnley; from *diphtheria*, 1·2 in Hornsey and 1·6 in Wolverhampton; from whooping-cough, 1·0 in Glasgow, 1·3 in Tottenham, 1·4 in Coventry, and 1·5 in West Bromwich; and from *diarrhœa*, 1·1 in Walsall and in Oldham, 1·3 in Walthamstow, 1·4 in Merthyr Tydfil, and 3·0 in Great Yarmouth. No death from small-pox was registered in any of the large towns.

Spotted Fever in Glasgow.

OWING to the large number of cases of cerebro-spinal meningitis which have occurred in Glasgow during the past three months—in all some 44 cases—the Town Council have decided to hold a special meeting to consider the advisability of including the disease for one year among the infectious diseases which are compulsorily notifiable to the health authorities.

Queen Alexandra Sanatorium

IN the absence of Lord Balfour of Burleigh, who is abroad, Lord Burghclere presided at the third annual general meeting of the Queen Alexandra Sanatorium, Davos. As soon as the necessary amount has been raised the sanatorium will be built upon a site already bought for the purpose near Davos. The sum collected so far according to the report presented on the 27th ult., reaches £13,536, of which close on £500 was subscribed last year. The amount still required is £17,500. Lord Burghclere stated that the plans would accommodate sixty patients. He believed by next spring the building would be commenced in earnest. The estimate of the total cost of the building and furnishing was approximately £22,000.

The Jubilee of the Catholic University School of Medicine.

THE Catholic University School of Medicine in Dublin celebrated its Jubilee last week, amid general congratulations. The festivals consisted of an athletic sports meeting on the 28th ult., a conversazione at the Mansion House on the 29th, and a dinner on the 30th ult. At the dinner about 150 guests sat down under the chairmanship of Sir Christopher Nixon, while in an adjoining room about 200 students dined under the chairmanship of Mr. McArdle.

Dr. Mannix, President of Maynooth College, proposed the only toast of the evening, "The School." Fifty years ago he remarked, the School was founded to vindicate a great principle, and to fight a great cause. In the fifties there were no big endowments to attract students to their University. There was no inherited prestige to confer real or imaginary importance to the teaching given within its walls, but yet the School from the first lived and flourished, and never during its fifty years history was it stronger, more flourishing, more vigorous, and more hopeful than to-day. Their grievance in the Medical School was but part of a larger grievance that kept the people of the country without University education worthy of the name.

Sir Christopher Nixon, Bart., who was cordially greeted, said he would like to say in respect to his own position in regard to the vital University question that he maintained that the question of the University in which they should seek for their degrees was not really such a vital matter, if the means of educating their students were provided in such a way as fully justified their reasonable demands. Whether that University were the University of Dublin, under such conditions of equality as would secure what was involved in the Catholic claim, or the Royal University under the altered conditions proposed in the recommendations of the Commission made very little matter.

Apothecaries' Hall, Ireland.

THE Summer Medical Examinations will commence with the First Professional on Monday, July 16th, 1906. All entries should be made at once with the Registrar, 40 Mary Street, Dublin.

The Royal University of Ireland.

THE following candidates have passed the First Examination in Medicine :—Michael J. Ahern, William F. Algeo, William W. Allison, Harold Black, Francis J. Burke, Sarah E. Calwell, Patrick E. Carroll, Frederick Carson, Louis Cohen, Pierce Cotter, Robert C. Cummins, Thomas A. Daly, Herbert Emerson, Thomas Fitzgerald, Michael J. Fogarty, Philip J. Gaffikin, George S. Glass, B.A., Harry P. Hannigan, Charles A. P. Harrison, William S. Haydock, Timothy F. Hegarty, Daniel Higgins, Thomas H. Houston, Melville C. Irwin, George Jackson, Ignatius P. Kelly, Robert A. Kerr, Thomas J. Kilbride, Patrick D. McCullen, Louis J. E. McHugh, Thomas P. McMurray, Henry P. Malcolm, Michael Moloney, Alfred J. Moran, Henry C. Mulholland, Laurence P. Mulligan, Denis Murphy, Joseph E. O'Sullivan, William Paul, William Prendiville, Thomas Reynolds, James J. Ryan, Gerard Shendan, Charles J. Simpson, John Stephenson, Walter Stevenson, James Stewart (Sch.), Bernard Telger, Samuel J. Turkington, William Turner, Robt. W. Vint, James R. White, Timothy Woulfe.

Trinity College, Dublin.

THE following candidates have passed the Final Medical Examination :—Part I.—William Pearson, Robert E. Wright, George F. Graham and John A. L. Hahn equal, Allman J. Powell, Frederick Stevenson, Henry de C. Dillon, Charles H. O'Rorke, Edward C. Stoney, Richard G. S. Gregg, James C. C. Hogan, Wilfred J. Dunn and Henry J. Keane equal, John W. Lane and William S. Thacker equal, John H. Morton, Edmund H. Sheehan, James E. M'Farlane, Joseph H. Elliott, and Eleanor E. Finegan equal.

Final Medical Examination. Part II.—*Surgery*—John C. P. Beatty, Francis R. Coppinger, Thomas H. Peyton, Edward Gibbon, Lily A. Baker, Thomas L. de Courcy, Henry D. Drennan, George Dougan, Ernest C. Phelan, Ernest C. Crawford, Thomas J. Cobbe, John B. B. Whelan, Ernest D. Caddell.

MEDICAL APPOINTMENTS TO THE POST-OFFICE, GLASGOW.—There is great excitement in medical circles in Glasgow over the appointment of a Medical Officer to the General Post Office. Applicants have been flying to London, and the lives of the local M.P.'s have been by no means rendered happier by the ceaseless importuning they have been subjected to. It has been definitely decided to appoint six medical officers for the City, so that direct personal supervision of the sick may be ensured. Private practice will likewise be permitted.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS.

ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT GYNÆCOLOGICAL AND OBSTETRICAL LITERATURE.

A Contribution to the Operative Treatment of Puerperal Pyaemia.—Archibald Cuff (*Journ. of Obst. and Gyn.*, May, 1906) says the clinical picture presented, when septic processes dependent upon micro-organisms, generally streptococci, having their seat in the endometrium, spread to and involve the pelvic venous plexuses and the large veins leading from them, is a somewhat varying one. This variation depends, as is always the case in infection, on the site and extent of the structure affected, and on the virulence and quantity of the toxin at work. Illustrative of these variations of virulence the writer mentions the not uncommon condition of "white leg," where the process is limited closely to the affected veins, as an example of the mildest form of vascular infection, and contrasting markedly with this condition is the one presented by what is clinically known as acute puerperal pyæmia. Here virulent micro-organisms invade the veins of the pelvis, and within two or three days produce a condition of the utmost gravity. Between these two extremes we have those cases which, often distinguished by their later onset, their more extended course, and their slower effect upon the general condition of the patient, are described as subacute or chronic pyæmia. The mortality of these chronic cases is also considerable. Bumm, in the Charité Hospital, Berlin, lost nineteen out of twenty-three cases in which an abscess arose in the course of the disease, although cases where abscesses occur are believed to have a better chance of recovery than those which run their course abscess free. Fochier, of Lyons, struck by this undoubted clinical fact, produced abscesses artificially by the subcutaneous injection of turpentine, and though his supposition that such abscesses produced their effect by attracting to themselves micro-organisms has been proved to be wrong—the abscesses being sterile—be the reason what it may, several successful cases have occurred. Removal of the uterus was next advocated, but this in the hands of Freund, Trendelenberg, and Bumm was a failure. Trendelenberg next modified the suggestion, and tied and cut the right internal iliac and the right ovarian veins and saved his patient. More recently, papers by Michel, Bumm, and Hæckel report successes, the procedure adopted being transperitoneal ligature of the thrombosed veins, the internal iliac veins generally, and after them the ovarian veins if necessary. The author then cites a case successfully operated on by himself, in which a rigor occurred two days after delivery; temperature 104°, pulse 126, and respirations 36. There was no uterine tenderness nor foul discharge. Temperature continued high notwithstanding douching and curetting, and fifteen days later a doughy lump, size of fist, not very fixed, was apparent in right broad ligament; temperature 105°, pulse 132, and respirations 26. Twelve days later laparotomy disclosed the mass to consist of thrombosed veins; these were ligatured on the uterine side with strong catgut, a second ligature being placed further out towards pelvic wall, and finally the right ovarian vein, which was thrombosed also, was ligatured half-an- inch from its junction with the vena cava. F.

Therapeutics of Retroversion of the Gravid Uterus—Rizzatti (*Annals of Obstet. and Gyn.*) describes the methods of treatment employed in the clinique of Professor Fabbri, at Modena. Whenever a woman is found to have a retroverted or retroflexed uterus in the early months of pregnancy, attempts are at once made to correct the malposition whether there be symptoms or not. According to Bossi abortion is a much more frequent termination to gravid retroversion than is spontaneous reposition, though the contrary is commonly held. The obstacles to the reposition of a non-adherent uterus are three, viz., gravity, friction, and especially negative pressure below. The author holds that even in non-gravid retroversions, this negative pressure is often a hindrance to reposition. He then gives Fabbri's method. With the patient in the "genu-pectoral position," a catheter is passed into the rectum, and with one or two fingers in the rectum, pressure is made on the fundus, while traction with a forceps is made on the cervix. In many cases the simple entry of air into the rectum with the patient in this position, is all that is necessary. F.

Prevention and Treatment of Puerperal Sepsis in Private Practice.—Stone (*New York Med. Journ.*, June) lays stress on the following points: Asepsis is the principal of obstetric technique. It is to be attained by (1) the use of no antepartum douches unless it is necessary to protect the baby's eyes from a purulent vaginal discharge; (2) sterilisation of external genitals and attendant's hands; (3) no postpartum douches unless specially indicated. Sterile towels are difficult to obtain, but freshly laundered towels dipped in bichloride solution and wrung out dry are good substitutes, and should be placed beneath the hips and round them; shaving the vulva is as important as in other vaginal operations. Separation and eversion of the labia before introducing the examining fingers is important. After delivery the external genitals should be washed frequently by a nurse with hands sterilised as for an operation. The use of rubber gloves is advised, especially for those engaged in general work. If fever appears after labour, the breasts and constipation being excluded, a systematic examination of the genitals should be made, beginning with the perinæum, then wiping away vaginal discharges and inspecting the vagina and cervix. Aseptic treatment of any wounds in these regions by irrigation with normal salt solution is usually efficient. Having ruled out these organs, the interior of the uterus is examined with the fingers while pressing the fundus down firmly. A bacteriological examination of the interior of uterus should be made. Putrid remains of gestation products should be removed digitally or with the aid of a sponge forceps. The rough placental site must not be mistaken for retained decidua. The uterus is then irrigated with hot saline solution. Ergot is given internally to maintain good uterine contraction. If cellulitis or peritonitis is present an ice-bag is applied to the abdomen, and, later, prolonged hot vaginal douches are given to aid absorption of the exudate. If an abscess is present it is opened in the most accessible region; hysterectomy is rarely required. F.

Hebotomic or Symphysiotomy.—Sellheim, Freiburg (*Monats. f. Geb. u. Gyn.*, March, 1906) considers, as the result of anatomical investigations, that severe injuries of the blood vessels, &c., may be prevented during hebotomic, if the operator, when passing Döderlein's needle, keeps as close as possible to the lower surface of the pubic bone. Even though the danger of hæmorrhage after sawing of the bone requires the exercise of great care, still this must not be driven too far, or the enlargement of the pelvis may not be satisfactory. One must not only saw till the bone is divided, but also till there is free room in the soft parts. In every case, before removal of the saw, it is important to see that the two parts of the brim are well separated. The amount of pelvic enlargement is the same after both operations. The equality of the enlargement towards both sides of the pelvis also seems to be the same. On the other hand, three times as much force is required to bring about an equal pelvic

enlargement after subcutaneous hebotomic as after symphysiotomy. So it may be understood that the soft parts, when retained as in the hebotomic, are a great protection against injuries. The principal protection against severe irreparable injuries to the sacro-iliac articulations, during both operations, lies in the ligaments. In the Klinik in Freiburg, after both operations the woman is allowed to deliver herself if possible. In all cases of both operations which have been performed the author has found permanent enlargement of the pelvis. He would not yet like to decide which of the two operations is really the better.

G.

Hæmorrhages from the Female Genital Organs, and their Treatment.—Döderlein, Tübingen (*Deuts. Med. Woch.*, 1905, No. 47), lays special stress upon the great importance of making as careful an investigation as possible into the cause of the hæmorrhage in every case. A bi-manual examination must be made, and, when necessary, the curette, with removal of portion of the cervix and microscopical examination, must be employed. In the first part of the paper he considers specially the climacteric and post-climacteric hæmorrhages. The so-called "return of the periods," that is, hæmorrhage sometime after the menopause, is almost pathognomonic of carcinoma. These post-climacteric hæmorrhages are usuall y irregular, while the climacteric hæmorrhages which arouse suspicion of myomata are evidenced by increase in the quantity and prolongation of the menstrual flow. During the age of sexual maturity, from the fifteenth to the forty-fifth year, nearly all gynæcological affections may be considered causes of hæmorrhage, *e.g.*, malpositions, inflammations, new growths, abortion, tubal pregnancy, &c. Tubal pregnancy, of course, deserves particular attention in making a diagnosis. As regards treatment, Döderlein protests against indiscriminate curettage of the uterus. He reserves the latter for special cases only, and among them he includes particularly fungous endometritis before the menopause. In acute infective processes of the uterus or its neighbourhood, curettage is strongly contra-indicated. It is also dangerous where myomata are present. In cases in which uterine cauterisation is employed, this process must be carried out with great caution. He does not consider it advisable to vaporise the uterus during the child-bearing period. For preclimacteric, and climacteric hæmorrhages in which diseases such as carcinoma, myoma, &c., can be excluded he found vaporisation most useful. In many cases the menopause resulted, and in others the menstruation became regular and no longer excessive.

G.

Cæsarean Section with Fritsch's Transverse Fundal Incision.—The advantages of this incision according to K. v. Simrock (*Centralblatt f. Gyn.*, 1906, No. 23) are as follow: Entrance of liquor amnii, meconium or blood into the abdominal cavity can be more easily prevented. The patient lies with the pelvis high, and consequ ently the fundus uteri occupies the lowest position, and it is impossible, after lifting the uterus out of the abdomen and shutting off the abdominal wound, for the uterine contents to get into the peritoneum. The hæmorrhage from the uterine incision is much smaller and more easy to stop. The technique is simpler. The muscular wall being of uniform thickness at the fundus, the suturing is more readily accomplished. The child is delivered very easily, because it is generally more than half-born spontaneously, owing to the retraction of the uterus over it from the contraction of the cervix and lower uterine segment. The uterus contracts more strongly and more quickly than after the vertical incision, consequently the wound becomes shorter, and the mouths of the vessels are much narrowed, or, perhaps closed. According to statistics the placenta is very rarely situated in the fundus, therefore it is not often encountered in the incision. Further, when Porro's operation is required, the amputation can be done at a higher level than when the vertical incision is employed, and the abdominal incision can also be made higher up and thus a hernia more easily prevented. Among the last thirty-seven Cæsarean sections in the Frauenklinik, Bonn, with this method there was a mortality of 5·55 per cent. When the patients who were septic before the operation are not included the mortality falls to 4·08 per cent. When there is severe hæmorrhage during the operation the cervix and broad ligaments may be compressed, but it is better not to do this, if possible, because it easily produces secondary atony. Strict asepsis, and very careful suturing of the uterus give the best promise of complete healing.

G.

The Entrance into the Tubes of Fluids Injected into the Uterus. — Buttenberg (*Munch. Med. Woch.*, 1905, No. 35) has experimented on dead bodies in order to discover when this is most likely to take place. The negative result of the experiments can be applied to the living organs, because if inert dead tissue could prevent fluid from entering the tubes *a fortiori*, living tissue could do so. The results of the experiments are as follow: By using a return flow catheter the tubes are rarely opened up, but with the ordinary single catheter they are opened in the majority of cases. It is unusual for a large quantity of fluid to gain entrance. When using Braun's syringe in cases where the cervical canal is narrow, fluid is always driven into the tubes when the pressure is high and there is much liquid injected. Low pressure, withdrawal of the fluid and the use of small quantities at a time, nearly always prevent the entrance of fluid into the tubes. It never occurs during treatment of the uterus with solutions applied on swabs.

G.

The Treatment of Mastitis.—Bauer (*Centralbl. f. Gyn.*, 1906, No. 23) has successfully treated twenty cases of mastitis by the hyperæmia produced by suction. The suction bell was applied in each case for five to ten minutes at a time, and then a pause of three minutes was allowed. The duration of this treatment in the early stage is from forty-five to sixty minutes daily. Later, twenty to thirty minutes are sufficient. Between the applications a sterile suspensory bandage is worn. When pus is present an incision ½ to 1 cm. long is made. In early cases the mammæ are normal after three or four days' treatment, and when the pus formation is not very extensive success is attained on an average in from sixteen to twenty days.

The Nose and the Genital Organs. — The close reflex relation between the olfactory and the genital organs has been a subject of observation ever since ancient times, and in our own day a condition called "nasal dysmenorrhœa" has been described, which is said to disappear as the result of suitable treatment applied to the nose. Bearing these facts in mind, Jerusalem and Falkner (*Weinec Wochenschrift*, 1906, No. 15), have devoted some scientific study to the relations between the nose and the genital organs of the female, particularly in regard to parturition. They find that in many cases uterine contractions were stimulated by the application of electrical stimuli to the "genital spot" of the nasal mucous membrane, and that the patients most easily influenced were those who had previously suffered from dysmenorrhœa. The movements produced, however, were less than were easily produced by ordinary means. On the other hand, cocainisation of the nasal mucous membrane gave marked relief to the pains of labour, without interfering in any way with the strength of the uterine contractions. Puerperal after pains were treated with similar effect, a single application of cocaine being in most cases sufficient to abolish the pains. It is possible that these results are due to suggestion, but if suggestion be excluded they seem to promise some practical utility.

R.

NOTE.—*A Summary will appear each week in the following sequence*:—(1) "*Recent Medical Literature.*" (2) "*Recent Surgical Literature.*" (3) "*Recent Gynæcological and Obstetrical Literature.*" (4) "*The Recent Literature of Physiology and Pathology.*"

NOTICES TO CORRESPONDENTS, &c.

☞ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, to 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 proofs.

PHYSICAL EXAMINATIONS FOR THE ARMY MEDICAL SERVICE.

A CORRESPONDENT, who is desirous of entering the Army Medical Service, writes to ask us if a defect of the left hand, caused by an accident some months ago, will be a physical disqualification for the service. In reply we would refer him to pages 4 and 5 in the regulations for "Commissions in the Army." A copy of these regulations can be had free on application to the Army Medical Department, 68 Victoria Street, Westminster. As the physical infirmity referred to by our correspondent appears to be slight, we communicated with the Director-General of the Army Medical Service, who informs us that it cannot be determined without examination whether the disability would be considered a disqualification or not, but that our correspondent could have the preliminary medical examination referred to in the regulations.

A BOLTON PRACTITIONER.—Cardiac paracentesis can be carried out with almost perfect safety, provided that rigid asepsis be preserved throughout the operation.

AN EAST-END "POGROM."

AN amusing occurrence is reported from New York, where the Jewish parents of some 6,000 scholars tried to storm the schools. They were under the impression that the wholesale removal of adenoids, to which their children had been subjected, was intended to prevent them speaking Yiddish. The Hebrew race is specially prone to adenoids, but as a rule their intellectual powers are more receptive of new ideas than might be inferred from the foregoing incident.

POISONING BY PHARAOH'S SERPENT.

THE toy known as "Pharaoh's Serpent," formerly in immense vogue, but hardly ever heard of now-a-days, was recently answerable for the death of a child in Nottingham. It consists of a pellet, which on being ignited swells up into a long, bulky, wrinkled ash, somewhat resembling a snake. Its chief active ingredient is mercuric sulphocyanide, a highly poisonous substance that comes under the schedule. On that ground the vendor of the pellets, which were swallowed by the deceased child, is being charged with manslaughter.

THE FASHIONABLE COMPLAINT, APPENDICITIS.

A CORRESPONDENT writes us:—"We have now come to regard 'appendicitis' (especially if we have been fortunate enough to escape death by operation) as a certain passport into the best and most exclusive society! The time is fast coming when a well-bred person will as soon think of carrying about a 'verniform appendix' as he would of leaving stick or umbrella at home when going for a walk."

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JULY 4th.

OBSTETRICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8 p.m.: Specimens will be shown by Dr. H. R. Spencer, Dr. H. R. Andrews, Dr. Eden, and Dr. Foulerton. Short communications:—Dr. C. N. Longridge: A Short Note on 64 Cases of Contracted Pelvis.—Dr. H. Williamson: A Case of Adenoma of the Labium Majus. Dr. A. Louis McIlroy: Demonstration with the epidiascope on Primary Cancer of the Ovary.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. M. White: Clinique. (Surgical). 5.15 p.m. Lecture:—Dr. C. Watson (Edinburgh): Diet Therapy in the Light of Recent Research, with Special Reference to the Use of Animal Proteid Food (with lantern demonstration).

LONDON SCHOOL OF CLINICAL MEDICINE (Dreadnought Hospital, Greenwich).—2.30 p.m. Operations. Dr. F. Taylor: Medicine. 3.15 p.m. Mr. M. Robson: Surgery. 4 p.m. Mr. Cargill: Ophthalmology. Out-patient Demonstrations:—10 a.m. Surgical and Medical. 11 a.m. Eye.

THURSDAY, JULY 5th.

NORTH-EAST LONDON CLINICAL SOCIETY (Tottenham Hospital, N.).—4 p.m. General Meeting.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m. Lecture:—Dr. C. Watson (Edinburgh): Diet Therapy in the Light of Recent Research, with Special Reference to the Use of Animal Proteid Food (with lantern demonstration).

LONDON SCHOOL OF CLINICAL MEDICINE (Dreadnought Hospital, Greenwich).—2.30 p.m. Operations. Dr. G. Rankin: Medicine. 3.15 p.m. Sir W. Bennett: Surgery. 4 p.m. Mr. M. Davidson: Radiography. Out-patient Demonstrations:—10 a.m. Surgical and Medical. 12 noon. Ear and Throat.

FRIDAY, JULY 6th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Dr. E. Waggett. Clinique. (Ear).

LONDON SCHOOL OF CLINICAL MEDICINE (Dreadnought Hospital, Greenwich).—2.30 p.m. Operations. Dr. R. Bradford: Medicine. 3.15 p.m. Mr. McGavin: Surgery. Out-patient Demonstrations:—10 a.m. Surgical and Medical. 12 noon. Skin.

SATURDAY, JULY 7th.

LONDON SCHOOL OF CLINICAL MEDICINE (Dreadnought Hospital, Greenwich).—2.30 p.m. Operations. Out-patient Demonstrations:—10 a.m. Surgical and Medical. 11 a.m. Eye.

Vacancies.

Brompton Hospital Sanatorium, Frimley.—Assistant to the Medical Superintendent. Salary £100 per annum, with board, lodging, attendance, and washing. Applications to the Secretary, Brompton Hospital, London.

City of Nottingham Workhouse Infirmary.—Resident Medical Officer. Salary £130 per annum, with apartments, board, washing, and attendance. Applications to G. Muncaster Howard, Clerk to the Board, Poor Law Offices, Nottingham.

County Lunatic Asylum, Lancaster.—Male Assistant Medical Officer. Salary £150 per annum, with board, lodging, and washing. Applications to the Medical Superintendent.

Egyptian Government.—Ministry of Education.—Professor of Midwifery and Gynæcology. Salary £400 a year. Applications to the Director, School of Medicine, Cairo, Egypt.

Egyptian Government.—Ministry of Education.—Medical Tutor and Registrar to Kasr-El-Ainy Hospital. Salary £400 a year. Applications to the Director, School of Medicine, Cairo, Egypt.

Galway Hospital.—Resident Medical Officer and Compounder of Medicine. Salary £75 per year, with apartments and rations. Immediate application to S. J. Leonard, Clerk. (See advt.)

Littlemore Pauper Lunatic Asylum, near Oxford.—Second Assistant Medical Officer. Salary £150 per annum, with furnished rooms in the Asylum, and board. Applications to Thomas M. Davenport, Clerk of the Visiting Committee, County Hall, Oxford.

London Open-Air Sanatorium, Pinewood, Wokingham, Berks.—Assistant Medical Officer. Salary £100 per annum and all found. Applications to the Medical Superintendent.

Royal National Hospital for Consumption, Ireland.—Two Physicians as (1) Resident Medical Officer; (2) Assistant Medical Officer. Salaries £100 and £50 per annum respectively. Immediate application to the Secretary, 13 South Frederick Street, Dublin. (See advt.)

West Ham Union.—Junior Assistant Medical Officer. Salary £140 per annum, together with the usual residential allowances. Applications to the Medical Superintendent at the Infirmary.

Appointments.

CROLL, W. F., M.D.Aberd., Medical Examining Officer to the Steam Fishers' Provident Society, Aberdeen.

GRAHAM, CECIL L., F.R.C.S.Eng., L.R.C.P.Lond., Surgical Registrar to St. Mary's Hospital, Paddington.

HARRISON, P. B., M.R.C.S., L.R.C.P.Lond., Resident Medical Officer at the Leeds Public Dispensary.

JOHNSON, L. CAPPER, M.B.Lond. and Vict., Ch.B.Vict., M.R.C.S., L.R.C.P.Lond., Honorary Anæsthetist to the Surgical Department of the Leeds Public Dispensary.

JORDON, ALFRED C., M.D.Cantab., Medical Officer to the Roentgen Ray Department of the Royal Hospital for Diseases of the Chest, City Road.

KENNEDY, J. C., M.B., B.S.Melb., Clinical Assistant to the Chelsea Hospital for Women.

SALMON ARTHUR GUY, M.D., B.S.Lond., L.R.C.P.Lond., M.R.C.S., L.S.A., Medical Officer of Health for the Bodmin (Cornwall) Rural District.

SOLTAU, ALFRED BERTRAM, M.D.Lond., F.R.C.S., L.R.C.P.Lond., Honorary Physician to the Plymouth Public Dispensary.

STOCKWELL, G. E. ST. CLAIR, M.B., B.C.Cantab., Clinical Assistant to the Leeds Public Dispensary.

Births.

BENNETT.—On June 28th, at Hillcrest, Northwood, the wife of Norman G. Bennett, M.A., M.B., B.C., L.D.S., of 50 Brook Street, Grosvenor Square, London, of a daughter.

COOPER.—On July 2nd, at Fownhope, Surbiton, the wife of Harry Cooper, M.A., M.D., of a son.

HANDFIELD-JONES.—On June 28th, at the Hermitage Box, Wilts, the wife of Ranald Handfield-Jones, M.D., of a daughter (stillborn).

JOHNSON.—On June 29th, at 3 Ellerker Gate, Richmond Hill, Surrey, the wife of John Robert Johnson, M.R.C.S., L.R.C.P., of a daughter.

MUNRO.—On June 30th, at 1 Oriel Villas, Cheltenham, the wife of D. G. McLeod Munro, M.D., M.R.C.P., of a daughter.

STEWARD.—On June 26th, at 125 Harley Street, London, the wife of F. J. Steward, M.S., F.R.C.S., of a son.

Marriages.

COLE—ROBERTS.—On June 27th, at St. Andrew's, Thornhill Square, London, Richard Charles Cole, H.A.C., to Miss Mabel Roberts, daughter of T. Andrew Roberts, M.R.C.S., 85 Richmond Road, London, N.

Deaths.

BRUORTON.—On June 11th, at his residence, Sandfontein, Uitenhage, Cape Colony, after a long illness, William Bruorton, M.R.C.S., L.S.A., late of Yetminster, Dorset, and Hornchurch, Essex.

COOKE.—On June 28th, at Burghfield, Berks, Robert Thomas Elsam Barrington Cooke, F.R.C.S., formerly of Scarborough, aged 78.

SHARPLES.—On June 26th, at Deal, Eleanor House, widow of the late William Sharples, M.R.C.S., of Leamington.

WATTS.—On June 29th, at Fern House, Henstridge, Somerset, suddenly, Lucy Anne, widow of Thomas Watts, M.R.C.S., late of Frampton-on-Severn, Gloucestershire.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIII. WEDNESDAY, JULY 11, 1906. No. 2.

NOTES AND COMMENTS.

Bone-setters' Certificates.

A WEEK ago we called attention to the cool assurance of a Herbalists' Association in publicly agitating for legislation to render it lawful for them to grant certificates of death. The reader of a paper at Grimsby recently commented on the dangerous modern tendency among business firms, clubs and other bodies to accept the certificates of so-called "bone-setters." From his own experience he was able to assert that certain railway companies and important insurance companies accepted certificates of the kind. Now, as anyone in the world, no matter how ignorant and knavish he may be, has the right to call himself a bone-setter, *ergo*, a certificate signed by a person so styled is no guarantee of any medical or surgical value whatever. The State has guarded the signature of legal medical documents so carefully that it will not even accept as valid the signature of medical men who have become duly qualified, but who have not taken the further voluntary step of registration. Can a State that refuses under such circumstances the certificate of a qualified (but unregistered) practitioner sanction medical certificates signed by persons having no medical qualifications whatever? Clearly, a bone-setter's medical certificate has absolutely no legal standing. This point is perhaps worthy of the attention of the Medical Defence Union.

How the State can Help.

THE Government derives some £3,000,000 annually from the patent medicine stamp duties. The public press and the printers draw an enormous income from the same source. It is hardly likely, therefore, that any of these interests will be readily worked up to the pitch of self-sacrifice involved in the abolition of quackery. In the matter of quack practice much might be done by influencing Government to exercise a stringent control of death certificates. The writer of the paper above quoted, Dr. Westlake, made a practical suggestion that would, if carried out, place a great obstacle in the path of the charlatan. His plan is to appoint a Government official specially to investigate all causes of death arising directly or indirectly from the treatment of unqualified persons. In that way the local prejudice which often prevails in favour of the offender would be counteracted; the popular mind would be educated by the publicity and importance of an official inquiry; and last, but not least, the police would find it less easy to shirk their obvious duty of criminal prosecution. There is little prospect of this excellent proposal bearing fruit. The voice of a medical journal raised in the interest of reform is like that of one crying in the wilderness. Had we a General Medical Council that took an interest in protecting the profession!—but we have not.

West Ham Workhouse Schools.

TROUBLES come apace upon luckless West Ham. The throes of the official inquiry into local Poor-law expenditure and management are still at fever-heat, when a fresh scandal is more than hinted at in a report presented by the Medical Officer of the Workhouse Schools. The condition of the infants' block he characterises as disgraceful in the extreme, 119 children being housed where there is accommodation for 44, with only one small day-room. "Disease has been rife during the past half-year," he adds. "Thirty children have measles. Disease always follows upon gross overcrowding, and I cannot be responsible for what may happen next. How far those in authority are free from blame in allowing a state of affairs to continue where unnecessary suffering is caused to children it is not for me to say." Accepting for the moment the last proposition, we cannot admit that the English Poor-law is so badly organised that it is not the duty of someone to speak out. The responsibility, from our point of view, rests with the Local Government Board, whose inspectors are presumably acquainted with what goes on in workhouses and workhouse schools. The abuses of the West Ham institution, assuming them to be as represented, must have been perfectly well known for a long time to the inspectors. If this matter comes before Parliament, as it should do, we trust that the position and the conduct of the Poor-law inspectors as well as that of the Local Government Board will be fully discussed.

A Curious Oversight.

WELL might the Wolverhampton Coroner remark, at an inquest held on June 29th, "This is the most remarkable case I have ever been called upon to investigate, although I have been here for fourteen years." The whole story reads like one of the ingenious fictions that characterise the work of some of

our modern sensational novelists. The deceased was a bookmaker and cigar merchant of the town, who, in accordance with modern canons of self-respecting tradesmen, was not above accepting hospital relief. Some six or seven weeks before his death, to be exact, on the morning of April 26th, his housekeeper found him "all smothered in blood," which he explained by saying he had had a fall. A medical man was called in, and next day deceased had six fits. Later he went to the Wolverhampton Eye Infirmary in consequence of having lost the sight of one eye. He was afterwards transferred to the General Hospital, and seemed practically cured. He was treated as an out-patient until his death.

The Bullet in the Brain.

THEN came the *post mortem* examination, which revealed a small scar in the right temple, a bullet in two fragments, a fracture of the base of the skull and an abscess of the brain. One fragment of lead had destroyed the optic nerve, and the other had lodged in the brain substance, where it had given rise to an abscess. How came the bullet in the brain? It was shown that deceased was a heavy drinker, and that on the morning, in April, when he was found covered with blood a revolver had been taken out of the bed. On the whole, there can be little doubt that the jury arrived at a correct verdict when they found that deceased committed suicide whilst temporarily insane. The value of a careful independent *post mortem* could hardly be more conclusively shown. The scar in the temple was about half-an-inch in diameter, white "with a black mark." It was partly hidden by the hair, and might readily escape observation. There was a fissure fracture of the bone leading from the perforation. The extraordinary fact remains that this patient, suffering from extensive cerebral injuries of definite traumatic origin, was under various medical men, probably at least half a dozen, who had no suspicion of the real nature of the malady. The case is certainly entitled to rank among the curiosities of medical history. It is calculated to make the flamboyant weaver of novels green with envy—but there it is.

LEADING ARTICLE.

WHAT IS WHISKEY?

ENGLISH law is an institution of which as a nation we may be justly proud. At the same time we are constantly reminded that while as an instrument of precision and of precedent it may be immaculate, that nevertheless its methods are slow, costly and cumbrous, its results often negative and disappointing, and its principles non-progressive. Some, at least, of these less desirable aspects have been abundantly illustrated in the whiskey appeal case. It is estimated that the costs to the two parties concerned must have amounted to any sum from £100,000 to £150,000. Yet no one is a penny the wiser as to the original problem as to whether the word "whiskey" is to connote spirit obtained from the old-fashioned pot still, or the substituted or partly-substituted product of the modern and far cheaper and less desirable patent still. Before any definition can be secured by the public and the distilling trade it is likely that another £150,000 will have to be spent in carrying the appeal to the House of Lords. If it be impossible to settle a question of such obvious public importance, except on terms of the extravagance here indicated, there need be no wonder at the increasing demand on the part of the democracy for reform in law. In the United States these things appear to be better arranged. The American Government, faced with a similar whiskey problem, has laid down an excellent definition to the effect that whiskey is the distilled product of fermented cereal grain properly matured by age. Four years is the minimum time fixed for maturing the spirit. Under this law the whiskey is closely inspected by Government inspectors at every stage of its manufacture. The consumer who wants pure whiskey has simply to see that he buys a bottle bearing the Government stamp. In other words, the Government of his country provides him with a means of distinguishing between pure grain pot still whiskey and substituted inferior spirit. With all the Anglo-Saxon common sense and thoroughness upon which we pride ourselves in the United Kingdom, we have not been hitherto able to fix a legal standard for whiskey. The question of purity of spirit sold for human consumption has a distinct bearing upon the temperance question. The newer and the cheaper the spirit the more is it calculated to cause acute and chronic alcoholism with all its attendant evils to mind and body. That fact has long since been recognised by the man in the street, as well as by scientific investigators, but it has been left to the practical American legislator to say that whiskey shall not be sold under four years of age. We have no hesitation in asserting that were a similar condition enforced in the United Kingdom it would tend to mitigate the evils of intemperance more than any other single conceivable measure. Why should the distillers claim to possess a sort of vested right to sell immature spirit that has been shown to be detrimental to life and health? As a matter of fact, the Government of the country has always been more or less unduly influenced by the preponderance of the brewing and distilling representatives in the legislature. In the interests of temperance, with which the future welfare of the nation is closely interwoven, it is to be hoped that the operations and conditions of the "drink" trade will be rigorously overhauled at no long future period. Viewed in the light of the legal proceeding in the recent whiskey trial, it almost seems that the bringing about of many pressing domestic reforms and advances must be preceded by a preliminary simplification, and, if needs be, modification of our present cumbrous legal administration.

THE Scottish Liberal Members of the House of Commons will entertain Dr. Farquharson at a dinner on Monday next in honour of his appointment as Privy Councillor.

NOTES ON CURRENT TOPICS.

The Annual Election of the Royal College of of Surgeons, England.

THE annual election of members of the Council at the Royal College of Surgeons, England, took place on Thursday last, and resulted in the re-election of Mr. Henry Morris and Mr. Richardson Cross, and the election of Mr. G. A. Wright, of the Owens College, Manchester. The latter was returned at the head of the poll, while the unsuccessful candidates were Mr. Charters Symonds and Mr. Bruce-Clarke. In one respect the election establishes a record, inasmuch as it has been marked by the return of two provincial Fellows. Probably Mr. Cross owes his success to the fact that he has already served one term on the Council; it is the usual custom for the Fellows to vote for a retiring Councillor who seeks re-election. On the other hand the return of Mr. Wright at the head of the poll is an indication that his candidature was ably organised. Much literature it is known was issued in his favour, while he secured the support, as a basis, of the whole of the electorate in the Manchester district. A great deal can be done, as the Association of Fellows proved, in these elections by efficient organisation. We congratulate Mr. Wright upon his success, and the Owens College upon its representative on the Council. Meanwhile, his return, in respect to "College politics," will be of little moment, since "College politics," so far as the Fellows are concerned, is dead; even the meeting of the Fellows, which was formerly always held after the declaration of the poll, was abandoned this year owing to the difficulty of obtaining a quorum, which was the case upon the past two or three occasions. Still, in the days of the activity of the Association of Fellows, much useful work was done at these meetings, as the result of which, among other concessions, the "common room" at the College was granted. But the only further reform for which the Fellows should agitate is that of the election of the President of the College. To the Council has been assigned the privilege of electing the President, whereas this duty should clearly belong to the corporate body of Fellows. The President of the Royal College of Physicians is elected by the general body of Fellows of the College, and so should the President of the Royal College of Surgeons by the Fellows of the latter. But nothing less than an earthquake would be equal to moving the conservative body in Lincoln's Inn Fields to agree to such a concession as this.

Pasteurism and its Critics.

SIR JAMES K. THORNTON, K.C.B., contributes to the July number of the *Humane Review* an article in which he establishes to his own satisfaction the thesis that not only is the Pasteur treatment for hydrophobia inoperative to prevent the disease, but that it actually produces it. The attitude of mind of people who argue in this way is perhaps of more interest to the mental pathologist than to any one else, but it is nevertheless deplorable to find a medical man, who has served his country with distinction, ready to accuse the great mass of his professional brethren either of gross fraud or of gross stupidity. He recounts at second hand several cases in which the Pasteur treatment is alleged either to have been unavailing or to have produced the disease. Having quoted two or three such cases, he remarks that "It is quite evident that these persons died from hydrophobia communicated to them by the Pasteurian anti-rabic treatment." That the Pasteur treatment does not in every case produce the disease is explained as due to the fact that in most cases the virus is so attenuated as to be harmless. Sir James Thornton also thinks well to dispose of "the kindred antitoxin treatment of diphtheria." "Many medical men," he says, "have indeed reported excellent results from the use of antitoxin in diphtheria, but these results were due to the carbolic acid, trikresol, or other preservative, which is always added to the serum." It is hardly necessary to give further examples of Sir James Thornton's methods of reasoning.

A New Pathological Society.

WE understand that a movement is on foot to found a pathological society for Great Britain and Ireland, something on the lines of the existing Anatomical Society. It is intended that it should not in any way interfere with existing local societies, but that it should form a bond of union between pathologists scattered in the different teaching centres of the three countries. Already a number of well-known pathologists, such as Drs. Sims Woodhead, Lorrain Smith, O'Sullivan, Bulloch, Lazarus-Barlow, Ritchie, Walker Hall, have given their adherence to the scheme. It is intended that the society shall be ambulatory, meeting periodically at different centres, and the first meeting is to be held next Saturday at Manchester. An interesting programme has been arranged, and the success of the undertaking seems already assured.

"Dropped Kidney"—Compensation Claim.

THE difficulties that surround claims for compensation for bodily injury are often great. They are familiar to most medical men under the guise of "railway spine," the best cure for which grave condition is the award of a good round sum in damages. Now that working men are amply safe-guarded by the Workmen's Compensation Act against injuries received in the course of their occupation, it behoves medical men to be more than ever cautious with regard to subjective symptoms. It would be adding a hundredfold to the labours of the Courts, for instance, were the validity of claims for dropped or dislocated kidney to be established. Such a case was recently tried in Birmingham, whose citizens have of late been more than once considerably exercised in mind over the "dropped" kidney question. In the County Court, Judge Bray dismissed the plaintiff's application on the ground that, assuming he was

suffering from dropped kidney, in his opinion it was not caused or aggravated by the alleged accidental strain. In view of the extreme obscurity and the many fallacies that surround a diagnosis of dislocated kidney, it certainly seems most unwise to base compensation claims upon any such assumption. On an issue of that kind nothing is easier than to produce an array of opposing medical opinions. To encourage litigation of this kind, therefore, is to risk the law's delays and uncertainties in an exaggerated form, while at the same time the dignity of the medical profession is bound to suffer more or less seriously.

The Herbalists' Charter.

FOR some obscure reason or other a certain class of journalist appears to take a malicious delight in anything that tends to lessen the dignity or encroach upon the rights of the medical profession. In pursuance of this spirit, the *East Anglian Daily Times* announces solemnly that "The doctors are up in arms against the application of the National Association of Medical Herbalists for a charter of incorporation." The petition in favour, it appears, of the charter has been presented to the King in Council, and has been advertised in the *Gazette*, in order that petitions for and against the proposal may be lodged before August 4th next. The attention of the Medical Defence Societies, of the British Medical Association, and of the General Medical Council may be drawn to this extraordinary procedure.

A Street Ambulance Organisation.

LORD CAMPERDOWN'S Committee of the House of Lords has struck out that part of a London County Council's General Powers Bill dealing with a proposed ambulance bill. This is the more to be regretted as the need for such a service was conceded on all sides. For once the City of London joined hands cordially with the London County Council, but objected later on the point of rating. Lord Camperdown promptly interposed to stop counsel for the promoters from proving the desirability of such a service, stating that no doubt could exist on the point. The chief ground for rejection appears to have been that the Council scheme was not sufficiently comprehensive. It is to be hoped that the Metropolis will not be much longer without an efficient system of the kind. A good modern organisation would involve central stations, alarms, telephonic communication, motor ambulances and a trained staff. What is true of London applies to all the great provincial towns, many of which are sorely in need of an efficient ambulance service. For that matter, something of the kind in rural districts would prevent a great amount of needless suffering and injury to life and limb.

Strike of Hospital Staffs.

THE people of Russia appear to be becoming past-masters in the art of strikes. By the concerted action of railwaymen a year or two ago the social and commercial circulation, as it were, of the nation was arrested. By a strike of six days' duration the Seamen's Union were enabled to bring the Minister of the Interior to accept their terms. But all other strikes appear to the imagination as pale and ineffectual before that which is now reported, of the whole of the hospital attendants of Odessa, to the number of 700. It is reported by the special correspondent of a London newspaper that the strikers carried off with them keys, medicaments and stores, while they abandoned 3,000 patients to their fate. It is hardly surprising to learn that this strike is reprobated by the public. Some sort of a parallel might be drawn by picturing a similar desertion of the hospitals in Glasgow, Dublin, Edinburgh, Manchester, or any of our great towns. A strike of the kind in St. Petersburgh, where there is an exceedingly large hospital population, would be terrible to contemplate.

A New Industrial Danger.

A SOMEWHAT sensational announcement was made last week at the Southampton Trade Union Conference. It appears that some months ago a new kind of wood was introduced to replace the boxwood shuttles used in the Lancashire workshops. After a few days the workmen who handled the new shuttles began to show signs of more or less serious sickness, and several of them died. An investigation was then undertaken by Professor Harvey Gibson, Dean of the Faculty of Science in the University of Liverpool. He identified the wood as West African satin-wood, and found that it contained a considerable quantity of alkaloid, which, being soluble in salt solutions, would be readily absorbed by a perspiring skin. Experimentally the substance proved to be an active cardiac poison, causing rapid death when injected into lower animals. The symptoms of poisoning are unofficially stated to be headache, sleepiness, running of the nose and eyes, chronic sneezing, giddiness, faintness and shortness of breath. This fresh industrial risk shows in an interesting way how science can often protect the labourer by laying bare the ultimate causes of disease. The financial importance of the incident will be apparent when we recall the fact that Lancashire supplies not only her own looms, but also those of Germany, Russia and India, so that a threatened strike among the English shuttle-makers would at once paralyse many European centres of industry.

Sewage Effluents in Drinking Water.

INCONSISTENCIES mark the progress of most practical steps in hygiene, in many instances, because of the inertia of public or private vested interests. They are nowhere more glaring than in the case of drinking-water in various parts of the United Kingdom, urban and rural. The Congress of the Royal Institute of Public Health

has more than once called attention to the subject. In their present Irish meeting the President of the Bacteriology Section, Dr. A. E. Moore, read a paper on Dr. Houston's report of the chemical and bacteriological qualities of London water for the six months ending April 30th. After some discussion the meeting unanimously resolved that the sources of drinking water should be above suspicion. The general proposition was followed by the more direct and particular resolution, also unanimous, "That in the opinion of this Congress, sewerage effluent of one town ought not to be taken as the source of supply of water for drinking purposes for another town." Opinions of this kind coming from an authoritative source, may reasonably be regarded as shadows indicative of coming events. Enlightened citizens will not go on drinking diluted sewage for ever, nor will they tolerate for all time the double outrage which first pollutes streams and rivers with sewage, and then sells the contaminated water at a high price to consumers.

The Bee Cure for Rheumatism.

A SO-CALLED "bee cure" for rheumatism has recently been exciting a good deal of attention in the United States. Not long ago one Frank McGlynn formed a theory that the sting of the bee was an antidote for rheumatism. It appears that several years ago he noticed that the chronic rheumatism from which he is a sufferer improved after he had been accidentally stung. When he had another attack he obtained equally good results from the use of the same remedy. Accordingly, in order to demonstrate his method, he permitted himself to be stung by one hundred bees at an apiary near Philadelphia, in the presence of some 2,000 persons who had gathered together to discuss bees and their habits. The action of such an application would be due mainly to violent counter irritation, which would doubtless have a beneficial effect upon most forms of chronic rheumatism. Possibly there might be formic acid or some other chemical agent in the bee-poison of medicinal value. The remedy, however, must be excessively dangerous. In the United Kingdom the sting of a single bee is sometimes attended with swelling and other inflammatory symptoms, of nervous, vascular and septic origin, that may even lead to fatal results. Then, again, it is well known that some persons are more susceptible than others to bee-poison. On the whole McGlynn's remedy appears to belong to that kind which is worse than the disease.

A Curious Medical Election.

CARDIFF is much exercised at the result of a preliminary weeding-out of candidates for the appointment of Medical Superintendent of the local asylum. There were no less than forty-seven applicants, some of them having a most distinguished record. The terms of the advertisement stated that canvassing, direct or indirect, would be a disqualification. It appears, however, that some of the candidates canvassed freely, thus gaining an undue advantage over those who adhered to the conditions. This flagrant violation is no doubt to a great extent answerable for the storm of angry rumours that has since gathered. Under the circumstances the wisest plan would probably be to refer the matter back to the Asylum Committee for reconsideration and further report.

Enteric Fever in an Asylum.

ON the 7th instant it was officially reported to the Metropolitan Asylums Board that on July 2nd there were fifty-five patients and two attendants under treatment for enteric fever at Belmont Asylum, and that seven persons had died of the complaint. Sixty-two uninfected patients had been transferred to a special fever hospital. At the time of report the cause of the outbreak had not been ascertained.

PERSONAL.

DR. J. M. ATKINSON, Principal Civil Medical Officer of Hong Kong, who is at present in England on leave, is returning to the Colony to resume duty next month.

DR. G. A. FINLAYSON has been appointed Pathologist to the Government of the Straits Settlements at Singapore.

AT the recent annual dinner of the Edinburgh Royal Infirmary Residents' Club, Sir Lauder Brunton, the retiring President, was supported by no less than seven of his fellow residents of 1866-67. David Christison, M.D., LL.D., was elected as his successor.

DR. HUGH J. M. PLAYFAIR has been appointed lecturer in Practical Obstetrics to King's College Hospital School.

MR. C. S. LOCH will open a discussion on the Relation of Sanitary Authorities to Charitable Organisations at the annual meeting of the Incorporated Society of Medical Officers to be held at Bath on July 14th.

AT the annual meeting of the Fellows of the Royal College of Surgeons of London, Mr. George A. Wright, of Manchester, was elected at the top of the poll into the Council of the College, while Mr. Henry Morris, of Middlesex Hospital, and Mr. F. Richardson Cross, of Bristol, were re-elected.

MR. DAVID HERON, M.A., St. Andrew's University and University College, London, has just published an interesting paper on national deterioration. His contribution is the first of a series upon the subject which the Department of Applied Mathematics of University College has been enabled to organise, thanks to the generosity of the Drapers' Company.

THE chairman of the Middlesex Sessions last week drew attention to the new Testaments provided for administering the oath. The covers were washable and any danger of microbes was minimised. The covers were of white composition, and the ushers were provided with cloths for the purpose of keeping them clean.

A CLINICAL LECTURE ON CARCINOMA.

Delivered at St. Bartholomew's Hospital, London, on May 23rd, 1906.

By CHARLES BARRETT LOCKWOOD, F.R.C.S.Eng., Surgeon to St. Bartholomew's Hospital.

GENTLEMEN,—It occurred to me that some cases of carcinoma at present in the wards would serve as a text for a clinical lecture to-day, and especially as each one of them raises points of very great importance with regard to the disease.

The first patient that I propose to refer to is a compositor. His age has little bearing upon the nature of his disease, excepting that carcinoma, which he has got, is one of the privileges of seniority. You must not, however, suppose that youthful people never suffer from carcinoma. Not infrequently carcinoma of the vermiform appendix has been found in quite young people, and, until microscopically examined, the disease has been supposed to be tuberculous in character. This patient came in with an ulcer at the posterior part of his rectum and anal canal. Some portion of it was removed and microscopically examined, and was found to be a columnar-celled carcinoma undergoing mucoid change. I attach no importance to that, because having watched cancers undergoing mucoid change, and also colloid change, I have not myself observed that it ever indicates any increased degree of malignancy.

This carcinoma was also examined under an anæsthetic before an attempt at removal was made. The examination under an anæsthetic was made, of course, to ascertain the extent of the growth. I should not say that, because the finger cannot be introduced beyond a carcinoma of the rectum, therefore the carcinoma is outside the possibilities of removal. But, obviously, if the surgeon cannot get his finger beyond a carcinoma of the rectum, he must of necessity remain in ignorance of its upward extent, and when an operation is attempted its removal may be found to be impossible. In this particular case, however, the finger easily passed beyond the carcinoma. Furthermore, the finger was unable to detect any enlargement of the glands in the sacral hollow. We, perhaps, hardly expected to find enlarged glands in the sacral hollow, because, as far as we could tell, the carcinoma was not of very long duration, and because we knew that this carcinoma was growing in the interior of his intestinal canal. A carcinoma growing inside the human intestine, or bladder, or stomach, or gall-bladder, is usually a long time in escaping to the exterior, and, in that way, differs from carcinoma of, for instance, the mammary gland, which possesses no capsule, or of the tongue, or the pharynx. This examination under an anæsthetic also showed that the finger could be passed on either side, thus proving that the growth had not extended into the ischio-rectal fossæ. Therefore, it was determined to remove this carcinoma.

But another very important point in the case had to be taken into consideration, because it was found, upon examination, that the patient's urine contained a very considerable amount of sugar, nearly three ounces of sugar in four pints of urine, per diem. That is a very considerable quantity of sugar to lose. Now experience has shown that major operations performed on diabetics are exceedingly dangerous. I remember, some time ago, being called upon to crush a stone for a patient who was found to have 3 per cent. of sugar in his urine. The stone had to be crushed because otherwise the patient could not continue in any way to perform his ordinary duties of life, and, besides, it was quite clear that life was a burden to him. Though seventy years of age, his prostate was but moderately enlarged, and in every other respect he was vigorous and strong. After considerable inquiry and consideration with regard to this case, the conclusion we came to was that, provided the sugar was under control, the operation might be undertaken with a reasonable prospect of success. It was found, when the patient was put on strict diet, and deprived of the sources of sugar, that the sugar almost entirely disappeared from his urine. So that the stone was crushed and the patient did exceedingly well, and in about a week's time was making arrangements for going home. But the weather suddenly turned exceedingly cold, and one day the patient became rather sleepy and very quiet. The next day he became still more sleepy and quiet, and afterwards became comatose and died of his diabetes. I do not know how that calamity could have been very well prevented. We had done all we could. He probably got the condition known as acetonæmia. I believe it is now customary to give people with diabetes, suffering from acetonæmia, considerable quantities of carbonate of soda in their milk or fluid. However, I know from my own personal experience that an operation of moderate severity upon a diabetic is a very perilous proceeding. Moreover, the ordinary septic bacteria are better able to grow and flourish in tissues impregnated with sugar than in the tissues of ordinarily healthy people.

With regard to this patient, whose case we are specially discussing, we set to work to get the amount of sugar in his urine under control, and I think I am right in saying that the amount had been reduced from 1,200 grains before operation to 36 grains after the operation had been performed. The operation was an ordinary straightforward cutting operation, and care was taken to guard against serious infection. After the operation was over the cut surface was dusted with iodoform, a drainage tube was passed into the rectum, and the wound was satisfactorily packed with iodoform gauze. As a result, any septic fluid in the rectum could pass out through the tube, and was not brought into contact with the newly-severed tissues. By the fourth day, when the tube was taken out, the cut surfaces of the wound had become sealed more or less securely by the usual processes of inflammation. The patient never had any serious degree of sepsis or even discomfort after the operation.

Now I come to another point with regard to this man. As I have already told you, when we made our first examination of his rectal growth by the usual microscopic process we found that it was a columnar-celled carcinoma. He has got a carcinoma inside the rectum; he has got the muscular walls of the rectum between it and the tissues on the exterior. That type of carcinoma does not seem very prone to spread along the lymphatics into the neighbouring glands, and that, I think, so far, is favourable for the man. But when we came to examine a large section of the growth we discovered that something else was proceeding. The man has got squamous epithelium in his anal canal, and this squamous epithelium is observed to be growing into his tissues, and the same is true of the columnar epithelium. This is a very striking fact, because he has got two types of carcinoma proceeding in his body at the same time. And these two kinds of carcinoma, I venture to say, are due to one cause. What is that one cause? There is one little point in his clinical history which throws some light upon it. The notes on his clinical history state that in 1898 he had some anal discharge, and had had anal discharge ever since. So that he has had some trouble there for many years. There was a patient in this hospital

who had had a granulating wound for nineteen years, and at last it became cancerous. Another man had an ulcer on the dorsum of his foot, and after twenty years it became cancerous. It would seem that if some people have an open sore long enough something may be planted upon it which makes it cancerous. I suspect that this man has had that sore open for a long time.

Another point: The subcutaneous surface of the anal canal sends its lymph into the lymphatics along Poupart's ligament, and onwards into the femoral canal, and so into the lower pelvic glands. The patient has been felt, to see what the glands of the groin are like, and these glands have been found to be slightly enlarged. They will require careful watching, and should they remain enlarged, and there be the slightest possible sign of their increase, then, in spite of the patient's diabetes, it will be necessary to do a rather considerable operation for their removal. At any rate, one of the large ones will have to be removed and examined there and then, in order to ascertain whether they are inflammatory or whether they contain carcinoma. I never believe that such glands are inflammatory until I have seen them.

Leaving that case, which, you may observe, raises many important points, I will pass on to another. This is a man who had quite an ordinary history. One day, he said he felt he must spit a little more than he had been accustomed to. Then at last he felt a sore and painful lump at the back of his tongue. Eventually an ulcer appeared there, and he came to this hospital with a tumour at the back of his tongue, containing a small irregular ulcer in its centre. For clinical purposes we may divide the tongue into thirds—the anterior, middle, and posterior thirds. I saw this man's tongue and felt the lump, and I saw that this lump had degenerated and ulcerated, and I began to think that it was certainly a carcinoma. The history stated that the patient had had that growth for three months. The carcinoma, if it was carcinoma, was not very large. But I have already said that if a person has carcinoma in any organ which does not possess a well-marked capsule, it will spread with extraordinary rapidity into the neighbouring lymphatic glands. Therefore, it became necessary to investigate these. To ascertain the condition of the lymphatic glands, it is, of course, essential that you should know where to find them. The lymphatic glands of the tongue—as described in a lecture which I delivered in this theatre, in 1904, and which was published in the June number of the *Clinical Journal*—are rather curious. You cannot reason about lymphatics at all; you can only observe the course of lymphatics. Nor is it at all easy to ascertain the course of lymphatics by a method of squirting fluids into the lymphatic glands and the lymphatic channels. To my mind, the results of disease are very much clearer if these results are supplemented by certain methods of injection. I will make a diagram of the tongue on the blackboard, with the posterior pillars of the fauces, and the lower jaw, and will divide the tongue into thirds. The lymphatics of the tip of the tongue open into the glands underneath the jaw. Now, if a patient has an epithelioma, as we not infrequently see, at the tip of the tongue, do not forget to feel underneath the mental processes of his jaw for the lymphatic glands there. The lymphatics of the middle tongue open into the glands in the floor of the mouth. These glands are certain to be overlooked if not correctly felt for. If you put one finger inside, and another outside, the mouth, you will feel the glands slipping beneath your fingers. These glands open into the sub-maxillary lymphatic glands, and in cases of carcinoma of the tongue, it may be wise to remove the whole of the sub-maxillary salivary gland for fear of leaving infected glands in its centre.

Now there is a trap into which we may fall. Here (illustrated on blackboard) is the man's neck, and the cricoid cartilage, and the lymphatic glands coming down the neck. In an operation to take away these glands it is necessary to make an incision which will go to the symphysis of the jaw, and thence down to the level of the cricoid cartilage, because the lymphatics of the middle third of the tongue often run straight down the neck to the cricoid gland. In the case of this man, the carcinoma is situated in the posterior third of his tongue. The lymphatics here pass down into the glands over the carotid artery. We sought for enlarged glands underneath the angle of the jaw, over the carotid vessels. The patient confessed to having drunk two quarts of beer a day, so that he is well supplied with adipose tissue. But I thought I could feel an enlarged gland underneath the angle of the jaw. Perhaps I was a little more dexterous at the feeling than some, and rolled that gland a little more skilfully under the tip of an assiduously trained index finger. However, we found enlarged glands under the angle of the jaw, and a series of enlarged glands over the carotid vessels. These glands were found to contain carcinoma, and also a huge mass of squamous epithelium, exactly like what you might have seen growing into the tongue. I am very anxious about the future of this man, and I will tell you why. There is his tonsil (illustrated on blackboard), and surrounded with lymphatics. The lymphatics around the carcinoma may have got into his tonsil lymphatics, and thence infected those in front of the vertebral column.

The lymphatics of the tongue have another peculiarity. Here (represented) is the tongue, and here is the lymphatic network across the dorsum of the tongue, and which carries lymph from one side of the tongue to another. I remember a lady patient who had a similar carcinoma removed from the left side of the tongue, and she did perfectly well for some time. But, a year afterwards, she came back, and then she was found to have got a carcinoma in the right side of her neck, in the glands underneath the right angle of her jaw. The infection had passed back over the dorsum of her tongue and thence found its way into the lymphatics of her neck. This man has not got a very pleasant future before him. With this in my mind I removed half of his tongue down to the epiglottis, and the lower anterior pillars of his fauces. It was worth his while to take considerable risk, in the hopes of obtaining future safety. So much for that man.

I am coming to another case operated upon a short time ago. This is a woman, and she raises another very important question concerning the spread of carcinoma, and, incidentally, concerning the proper methods of operating for it. In August of last year, a very stout woman was sent up from Hampshire with carcinoma of the left breast. I believe I am right in saying that she had had the carcinoma for at least two years, and the medical man who sent her up wrote to me at the time to explain that it was not his fault that the case had been allowed to proceed so far. I did the usual operation and removed, I trust, the whole mammary gland, which is a huge structure, as you are aware, and both pectoral muscles, and also did my best to remove all the axillary fascia and lymphatics. I went above and below the upper part of the axillary vein, and I think I left no trace of carcinoma below the clavicle. We had no reason to suppose, from our clinical examination, that there was any trace of carcinoma above the clavicle, though, of course, neither I nor you, nor anybody else would for one moment imagine that the clavicle is the slightest bar to the spread of carcinoma into the neck.

Now comes the next act in this drama. Not long since the patient returned, and it was quite easy then to feel an enlargement of the lymphatic glands in the posterior triangle of the neck. The carcinoma had obviously spread into the lymphatic glands there. How did it spread to these glands? It might have spread in several ways. One of its methods of spreading must have been this: Here (sketched on blackboard) in the clavicle, here the axillary vessels, and here the mammary gland. One way for the lymph

to flow is by passing underneath the greater and lesser pectoral muscles, and then onwards into the axillary glands, and upwards, over and under the vein into the glands of the posterior triangle of the neck. I suppose that is the usual way in which it flows, but that is not the only way. The lymphatic channels do not always take the longest route; not infrequently they take the shortest. In the case of the mammary gland there are lymphatics which pass from the mammary gland along the suspensory ligaments of that gland over the clavicle, into the subclavian glands, without going through the axillary glands at all. A patient, I remember, came back after having had her breast removed, and she had got an enlarged lymphatic gland, but in a very unusual place—in the upper thorax, underneath the sternomastoid. The cancerous lymph in that case did not go underneath the clavicle, because it then ought to have affected the subclavian glands themselves. I cannot help thinking that the lymph went straight upwards from the breast into the lymphatics underneath the sternomastoid. With regard to the patient whose case we are particularly considering, the enlarged lymphatic glands found in the posterior triangle of the neck were removed, and then it was found that she had got other lymphatic glands, which had been neither felt nor seen, underneath the sternomastoid. With some trouble these glands were also removed. I did not see the thoracic duct, but obviously that was not a very pleasant place to endeavour to remove adherent glands from.

Now the question is, Ought not I to have been rather wiser when first operating, and to have said to myself, "Here is a very stout woman who has a carcinoma which is known to have existed two years in the left mammary gland, and who is known to have considerable enlargement of the lymphatics in her armpit and axilla? Would not it be wise to carry the incision up through the clavicle and the posterior triangle of the neck, and see what the condition of the subclavian glands is, because you cannot see them through the skin?" And with regard to the lymphatics below the sternomastoid, you cannot feel them, especially if the patient is exceedingly fat, as this woman was. I am sure I ought to have done that. The omission of that precaution must very much have shortened this patient's days. I am getting to this stage of my thinking about carcinoma of the breast and indeed of all other regions—that it is becoming more and more necessary not to believe you can feel enlarged lymphatic glands, but to carry out an exploratory operation to see what is the matter with them. What a great comfort it must be to a patient, after the operation is over, to know that the lymphatic glands have been properly looked at, and that nothing has been found in them! You will find on the table a series of sections representing the cases that we have been speaking about, and I advise you very strongly to look at them all, because the time is rapidly coming when the surgeon will have to be able to look at microscopical sections and form his opinion finally upon them. Those who have not practised assiduously in this direction will be taken at a great disadvantage.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week's issue will be by Professor C. Yelverton Pearson, F.R.C.S., F.R.U.I., Professor of Surgery in Queen's College, Cork, "On Psoas Abscess: its Nature and Treatment," with notes of an illustrative case.*

AMONG the victims of a motor-car accident last week, near Hastings, we regret to find the name of Miss Ransford, Matron of the Buchanan Hospital, Hastings, who was killed on the spot. At the same time Nurse Minnie had both legs broken.

HUMANITARIAN.—Flogging for robbery with violence has greatly decreased of late years. A similar observation applies to flogging for breaches of prison discipline.

ORIGINAL PAPERS.

UNCOMPLICATED CHOLELITHIASIS: ITS MEDICAL TREATMENT.*

BY WILLIAM BAIN, M.D., M.R.C.P.LOND.

POST MORTEM records show that the presence of gall stones is often unrecognised during life. In some instances gall stones do not produce any definable symptoms, and it also occasionally happens that gall bladder symptoms are ascribed to some other organ. It is well known that in many of the cases that fall into the hands of the surgeon the patients have complained of indigestion for years, and as a corollary to this I may express my conviction that the disease is more common than known-cases indicate. Of the last 100 patients seen by me this year, 12 were cases of cholelithiasis—a large percentage, even for a health resort.

Before discussing treatment it will be convenient to glance at the pathology and symptoms of gall stone disease. It is generally admitted now that gall stones are the result of microbic infection of the gall bladder. The chief inciters of the inflammatory process are the bacillus communis, bacillus typhosus, staphylococcus albus and aureus, and the streptococcus pyogenes. Generally speaking, bacteriological examination shows the presence of only one micro-organism, but mixed infection is not uncommon. The gall bladder may be infected by: (1) the portal vessels; (2) the duodenum, and common duct, or (3) by the general circulation. The first important advance in the pathology of the affection was the production, experimentally, of gall stones by Gilbert and Fournier. To produce gall stones experimentally it was found that the degree of cholecystitis set up must be mild and that the organisms must be retained in the gall bladder for a short period. Moderately severe inflammation causing extensive structural alteration of the mucous membrane prevented the over-production of cholesterin and bilirubin calcium, which are, of course, essential to the formation of gall stones. The varying composition of gall stones points to differences in their mode of development. It is difficult to believe that the cholesterin and bilirubin calcium calculi are evolved by the same process. The cholesterin of gall stones is most probably derived from the desquamation and degeneration of the epithelial cells of the gall bladder. An interesting feature of these calculi is the re-crystallisation of cholesterin that takes place in the interstices of the stone—a phenomenon to which Meckel called attention. Regarding the deposition of bilirubin calcium, the acid mucin is probably combined with calcium and in catarrhal conditions of the mucous membrane it is likely that an increase in the calcium salts of the cystic bile occurs.

The significance of biliary stasis in the formation of gall stones was pointed out long ago. Modern authors regard it as the most important predisposing cause. The factors which favour the stagnation of bile are:—Too little exercise, tight lacing, stooping over desks, excessive eating or drinking by inducing duodenal catarrh, constipation, too long intervals between meals, pregnancy, Glenard's disease, cardiac disease, &c

What are the symptoms and signs of gall stone disease? It is very important that the affection should be recognised early, otherwise medical treatment may not be of much avail. The most frequent symptoms are indigestion, mental depression, irritability of temper, and a sensation of heaviness or discomfort in the right hypochondriac region. The physical signs are tenderness on pressure over the gall bladder and Boas' sign—that is tenderness on pressure in the right subscapular region. There may also be a slight enlargement of the liver and a sense of fulness in the gall bladder area; in some instances, a tumour is felt. When there is a definite history of biliary colic there can be no difficulty in diagnosing the

* Read at the Therapeutical Society.

condition, but some gall stone cases never had colic. In the absence of biliary colic we must rely on palpation for its recognition. I attach some importance to the method by which palpation is carried out. The plan I adopt is this: The hand is first placed immediately beneath the ribs on the right side of the abdomen, and the patient told to breathe quietly for a minute or two. It will be found that the hand sinks deeper in the abdomen with each expiration, so that the presence of a tumour or a tender spot will easily be detected unless the patient is very stout. The same process is repeated on the left side. If the right side is tender further investigation is unnecessary. Gall bladder tenderness must be differentiatcd from that due to the liver. If due to the liver the tenderness can be elicited along the lower border of that organ; if depending upon the gall bladder it is circumscribed. Further, the tenderness of the gall bladder is as a rule greater than that of the liver. By hooking the fingers underneath the right costal arch about an inch from the middle line, and asking the patient to take a deep breath, if the gall bladder is very tender inspiration suddenly stops when the organ comes into cotact with the examining fingers. The sensation produced by pressure over a sensitive gall bladder is testicular and radiating in character, at any rate, two of my patients so described it.

TREATMENT.

The treatment of biliary colic need not be discussed.

The treatment of gall stones may be considered under three heads:—

1.—General factors.
2.—Health resorts.
3.—Drugs.

In the general treatment are comprised suitable food, exercise, and clothing. The diet should, of course, be within the limits of the patient's digestive capability. A mixed diet is the best. A purely vegetarian diet is apt to produce fermentation. A fair amount of animal food is distinctly indicated in this affection, for it is well known that the bile salts tend to keep cholesterin in solution, and an increase in bile salts can be secured by a generous allowance of nitrogenous food. The all-important object is, however, to prevent or alleviate indigestion. The bowels should be evacuated daily. Exercise tells largely in the treatment. For elderly women walking or riding and respiratory exercises are the best, and for middle-aged men riding or golf. Chill should be guarded against. By lowering the resistance of the tissues it may lead to fresh activity of the invading micro-organisms.

The success of health resorts in the treatment of these cases depends upon a number of agencies: (1) diet; (2) exercise; (3) the daily cleansing out of the alimentary tract by aperient waters; (4) the flushing out of the tissues by saline fluid; (6) the soothing action of packs on the affected organ; and (7) mental repose.

DRUGS.

A great number of drugs have been tried to promote the dissolution of biliary calculi. The olive oil treatment is very ancient and has been advocated in most European countries. The experiments of Brockbank gave it a distinct fillip. He found from laboratory experiments that olive oil, oleic acid and sapo animalis dissolved biliary calculi in a few days. So does alcohol, but no one has ever recommended it in the treatment of gall stones. On the contrary, it is rightly vetoed. Among other drugs may be mentioned salicylate of sodium, salicin and benzoate of sodium, oleate of sodium, succinate of iron, calomel, salol and Durande's mixture, consisting of chloroform ether and turpentine. Recently some one recommended acetozone. Some practitioners believe in succinate of iron, but most men I find pin their faith to olive oil. Herter, discussing the drug treatment in 1903, said that "few facts have as yet emerged from the nebulous region of gall stone therapeutics."

Two years ago I began a series of experiments in the hope of finding a remedy for cholelithiasis. The method adopted was as follows:—After the animal was anæsthetised, the skin of the abdomen was prepared and a median incision, 2 or 3 ins. long, was made from the xyphoid downwards. The gall bladder was drawn forwards and held by Spencer Wells' forceps. It was then incised, the bills soaked up, and the stones inserted. Sutures were applied in the usual way, and in a majority of the experiments the gall bladder was stitched to the abdominal wall; in others it was dropped back into the abdominal cavity. When we wished to set up cholecystitis, a culture of the bacillus coli communis in normal saline was injected into the gall bladder before the last stitch was inserted. The mucous membrane of the gall bladder was gently scraped just before the stones were introduced, so as to aid the action of the micro-organisms.

A paper based on these experiments was published in the *British Medical Journal* last August. The following is a summary of the results:—

"(1) That gall stones introduced into a normal gall bladder become dissolved in a comparatively short time—about eight or nine weeks.

"(2) That when a mild degree of cholecystitis is set up gall stones inserted into the gall bladder do not disappear, although there is always a reduction in weight.

"(3) That ichthoform, cholelysin, olive oil, and calomel do not appear to have any effect in resolving calculi introduced into a gall bladder the mucous membrane of which is inflamed.

"(4) That during a course of the Harrogate old sulphur water gall stones become disintegrated in cases of cholecystitis experimentally induced.

"(5) That in the treatment of artificially produced cholecystitis a mixture of urotropin and iridin has a pronounced effect in causing dissolution of the calculi.

"(6) That in regard to the action of barium chloride further experiments are necessary to determine its *role* in experimentally produced cholelithiasis."

As a result of these experiments the plan I generally follow in treating patients is this:—I order a pint of the old sulphur water before breakfast and two tabloids of urotropin and iridin (5 grs. and 1) during the day. With each tabloid a glass of water should be taken, otherwise irritability of the bladder may ensue. In addition, a digestive aid, such as papain or pepsin, is frequently prescribed. Diet and exercise, too, receive careful attention. Mustard bran packs over the affected organ are very effective in diminishing the sensitiveness of the gall bladder.

Three of the patients so treated returned last month to be re-examined. One of these a lady, æt. 69, had been out of sorts for some years. She complained of indigestion and mental depression, and had lost flesh. On examination the gall bladder was found to be very tender on pressure. She could only stay ten days, but continued the urotropin and iridin for over two months at home. At her second visit she expressed herself as feeling perfectly well and had gained in weight. The tenderness over the gall bladder had completely disappeared. The result in the other two cases was equally good. I believe that in recent gall stone disease due to the typhoid bacillus, urotropin is a specific. If the condition has existed for a long time and the walls of the gall bladder largely converted into fibrous tissue, nothing short of surgical interference is effective.

MODIFIED METHOD FOR CURE OF ADVANCED STRANGULATED HERNIA.

By MICHAEL AMBROSE.
Assistant Surgeon, County Mayo Infirmary.

ON reading the different surgical text-books and literature on the subject of hernia during the past decade, one would imagine that the various procedures for "radical cure" had been exhausted

and that the profession was on a sure footing in declaring the twentieth century surgeon to be incapable of producing anything new on the subject. Regardless of such facts, hernia, like our mutual friend, the appendix, forms a field for useful and instructive literature in each successive year and adding procedures, one of which I mean to detail to you, for which, on recognising the frequency of the malady and being unable to find such a procedure already published, I ask no pardon.

On the morning of May 7th, 1906, T.G., a workman, æt. 30, and subject to epileptic seizures, was brought from one of the union infirmaries with the following history :—He received an injury some five years ago which resulted in an oblique inguinal hernia of the acquired type, and on seeking medical advice was supplied with a well-fitting truss with which he was able to perform manual labour without any inconvenience whatsoever. However, on the morning of May 2nd he forgot to put on his truss, and when engaged digging in the garden about three o'clock p.m. he was seized with a violent pain, followed some time after by vomiting, and had to be brought home to await the arrival of the local medical man, who came immediately, diagnosed strangulation, applied unsuccessful taxis, recommended immediate operation, and had him removed as soon as possible to the union infirmary, where taxis was again employed with similar results, from where he was transferred to my care on the fifth day of strangulation, in a condition of fever, vomiting and constipation (nothing but flatus coming away on administering the usual enema before operation), with deap-seated pain over the site of a left-sided strangulated inguinal hernia. In fact, if asked to sum up the symptoms on admission to hospital, I would say strangulation *plus* local peritonitis. Unfortunately, immediate operation had to be delayed owing to a return of the patient's old malady in the form of *grand mal* ;

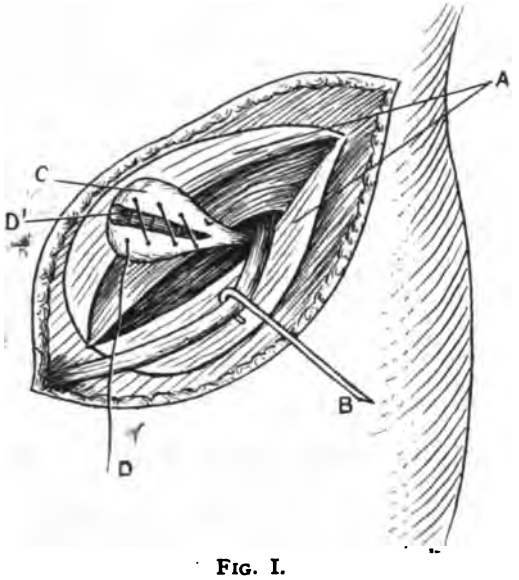

FIG. I.

A.—Divided portions of ex-oblique aponeurosis.
B.—Retractor holding aside and downwards spermatic cord.
C.—Sac opened and empty of contents.
D.—Continuous catgut suture closing sac, but leaving an opening D' near top.

nevertheless, I performed the following the same evening :—

I first did the usual procedure for relief of strangulation, and on opening the sac a quantity of extremely foul-smelling pus made its discharge, revealing an intestine of a deep claret colour, which latter underwent very little change on establishment of circulation, leaving me to believe the gut to be in a very doubtful condition.

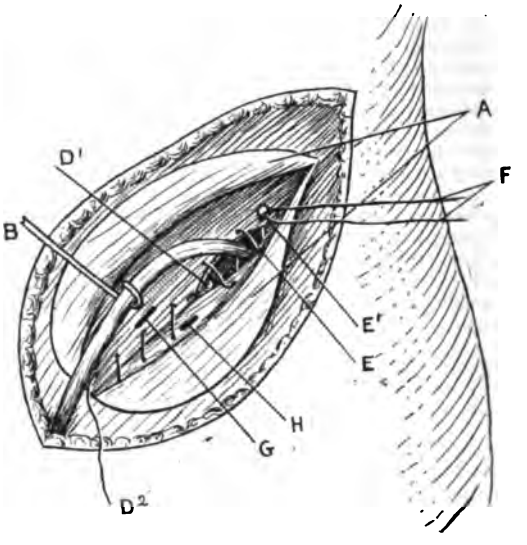

FIG. II.

A.—Same as Fig. I.
B.—Same as Fig. I., but cord in this case pulled upwards.
D'.—Open end of sac showing at top of sutured conjoined tendon (C') and Poupart's (H)
D².—Direct continuation of suture D, Fig. I.
E.—Catgut suture above opening of sac to fix sac and secure radical cure with loop E' on end of same when tightened (shown loose in figure for illustrative purpose).
F.—Silk thread passed through E' for drainage.

Nevertheless, owing to the delay of such procedure as resection when one had to consider the extreme collapse of the patient, and, on the other hand, that I have always regarded an artificial anus a far worse evil than the various complaints for which it is used as a relief, I decided on adopting a modified method and returned the bowel to the abdomen after copious antiseptic lavage of the sac and its contents.

The method consisted of a radical cure, and at the same time allowed drainage from the inflamed sac and bowel, so as to prevent secondary troubles, such as continued local or, what I feared most of all, general peritonitis. I had no need to fix the bowel, as owing to its inflamed and paralysed state it could not change its position (especially if some opium be subsequently administered).

So I turned my attention to the sac, which I sutured with a continuous catgut, leaving a small opening near the top. (Fig. 1.) I next passed the end of my suture through the anterior face of the conjoined tendon beneath the cord and through Poupart's ligament on the outer side, inserting three other stitches with the same suture as in Bassini's operation, with the exception that in this case I used a continuous suture during the whole process, and having the open end of sac,

now twisted on its long axis yet free enough to allow drainage from its interior through an opening about the size of a large pill, visible at the site of outlet of the cord. (Fig. 2.) My next step was to insert another catgut suture above the cord, passing the stitch first through the upper side of the sac near its opening in order to fix latter and secure the radical procedure, as we all know recurrence is not uncommon at this spot. To act as a guide to drainage to the opening in sac I passed a stout silk thread through a loop at end of catgut suture, leaving the former protruding through the sutured oblique muscles and skin on completing my operation according to Bassini. (Fig. 2.) As to after-treatment, I dressed the wound with warm boric stupes for the first four or five days, a quantity of foul discharge coming away, at the end of which time the discharge ceased, enabling me to take away the protruding silk thread by pulling on one end so as to free it from the loop of catgut. The open wound healed from the bottom by granulation, which latter insured against a recurrence of hernia at this the most liable spot; and the skin healed by first intention, with the result that the patient left hospital before the end of the month cured from his hernia and to-day is doing his usual manual work without a truss and suffering no inconvenience whatsoever.

In conclusion, allow me to tabulate the following items of interest :—

1. The delayed operation for relief of strangulation combined with excessive taxis produced acute local peritonitis.

2. Owing to the septic state of sac and its contents, it was desirable to establish free drainage in order to prevent further peritoneal complications.

3. Instead of leaving over the radical cure to some later date and establishing free drainage, as is usually resorted to in such cases, I combined the two methods by the procedure and with the results that I have detailed.

PULSE TENSION: ITS CLINICAL SIGNIFICANCE.*

BY H. W. SYERS, M.A., M.D.CANTAB.,
Physician to the Great Northern Central Hospital.

PART I.

GENTLEMEN,—The subject I have chosen for this evening's address is one of great and increasing importance, and this both as regards diagnosis and treatment. It is now perfectly clear that undue arterial tension is one of the most efficient causes of vascular degeneration, and the increased attention of the present day devoted to blood pressure observations has rendered it evident that alterations of tension occur in many and various morbid conditions, so that it becomes of paramount importance to determine whether or no abnormalities of arterial pressure are present in a given case.

Up to quite lately it has been the custom to gauge the blood pressure by the aid of the finger placed upon the radial artery; there can be no doubt that much valuable information as regards not merely the blood pressure, but also the condition of the wall of the vessel can be gained in this way. But it is obvious that accuracy and precision are not to be looked for by the adoption of this rough and ready method. For the satisfactory estimation of the arterial pressure instrumental assistance is essential. The instrument I have always used is the Riva-Rocci sphygmomanometer as modified by Mr. L. Mummery, and it is very easy to use this instrument the arrangement of which is well adapted for clinical purposes.

As I have just observed, much more attention than heretofore has of late been devoted to the subject of blood pressure and arterial disease. It would seem that to this cause, and not perhaps to any real increase in the occurrence of vascular disease is due the fact that arterial degeneration is much more often diagnosed than was formerly the case. However this may be, it is certain that disease of the arteries occupies at the present time a far more prominent place in the nosology than at any previous period.

Arterial degeneration may affect the aorta or peripheral vessels, or both; very often the aorta is alone involved. It is extremely important to be aware of the capricious manner in which arterial degeneration may be distributed; the circle of Willis may be in an advanced stage of disorganisation, yet the aorta and peripheral vessels may not display the least evidence of disease. When the aorta is involved it is very often the case that the lesion is limited to the arch of the vessel, terminating as it does more or less abruptly at the commencement of the descending thoracic or abdominal aorta. As a working rule, it may, I think, be assumed that when the temporal artery is thickened and tortuous so as to be readily perceptible to sight and touch, there can be little or no doubt that the cerebral arteries are in a similarly degenerated condition. At least the after history of patients presenting this abnormality is very often indeed that of cerebral hæmorrhage, either terminating fatally, or leading to hemiplegia.

In this connection it is of some clinical importance to examine the dorsalis pedis artery; it is sometimes the caset hat this vessel may be found to be more or less degenerate when the radial artery appears to be normal. In doubtful cases it is advisable not to forget this point.

It is of course the case that arterial degeneration is accompanied with increase of arterial tension, but the latter may be met with in the absence of those degenerative changes to which I have just referred. There can be little doubt that the persistence of high arterial tension, by abolishing the elasticity of the wall of the vessel, ultimately leads to the production of those degenerative changes which are so often met with in the arteries at *post mortem* examinations. The two conditions of high tension and degeneration of the arterial wall are connected by the closest ties, being indeed cause and effect.

This being so, it is obviously of the greatest importance to detect the tendency to high tension at the earliest possible moment, and to endeavour by every available means to bring about a more healthy condition of the arterial system.

I propose, this evening, however, imperfectly, to deal with the causation and treatment of this abnormal arterial pressure, and to consider the question of its relationship to other maladies.

And in the first place what is the cause of that arterial tension which is so often met with at the present day in middle and advancing life? I have long been convinced that the tendency to high tension and arterial disease generally is in a very large majority of cases an inherited tendency, one which reveals itself in generation after generation at or about the same age—from 30 to 40. And here the question of the relationship between gout and arterial disease of course arises. There can be no doubt that the link between these two maladies is one of the closest description. Certainly those who are gouty in the sense of a tendency to suffer from acute attacks of the affection are pre-eminently those who are liable to manifest increased arterial tension and eventually vascular degeneration. And I should here like to point out that gout in its most typical and acute form is very far indeed from being an uncommon malady amongst out-patients, so many of whom suffer, as is well known, from arterial disease. In this part of

* The Presidential Address delivered before the North London Medical and Chirurgical Society, Thursday, April 12th, 1906.

London, at all events, I can confidently affirm that most typical gout is an every-day occurrence amongst out-patients, both male and female.

During the many years I saw out-patients I was much struck by this fact, and I have observed the malady in quite young people. A most typical case was that of a boy of 15, and another occurred in the person of a boy of 13. In both these cases there was a strong family history of gout. It is therefore no matter for surprise that high arterial tension and consequent degeneration are constantly met with in out-patient practice. I repeat that I believe hereditary tendency to be at the foundation of morbid elevation of pulse tension.

Yet it cannot be denied that, given this abnormal tendency, various exciting causes may be at work. I feel confident that excessive smoking is one of the most injurious of these causes. I think we scarcely realise the enormous increase which has taken place in the smoking habits of the nation, more especially as regards the most pernicious misuse of the cigarette. It is only necessary to consult the trade returns to ascertain how prodigiously the use of tobacco has increased in this country. The enormous fortunes amassed in the tobacco trade of course point in the same direction.

Now a very simple observation made with the Riva-Rocci sphygmomanometer will convince anyone that even a few whiffs of a cigar will increase the blood pressure. What then must be the effect of arterial pressure when smoking is indulged in from morning to night almost without intermission? Palpitation is very commonly observed among youths and young men at the present time, and is I am sure much more often seen in the out-patient room than formerly. The cause is, I am persuaded, the use of tobacco. Especially injurious to these patients is the habit of cigarette smoking; to such an extent is this vice carried that it is by no means unusual to meet with those who never really cease smoking during waking hours; at all ages such abuse is injurious, but it is particularly so during adolescence, undermining as it does the very foundations of health. During the adolescent period and up to the age of 30 or so, experience has taught me that excess in the use of tobacco causes palpitation, intermission and irregularity of heart action; dyspeptic symptoms occupy but a secondary place. But in middle age it is the digestive system which primarily suffers, a very definite and characteristic form of dyspepsia being induced.

At a later period it is again the heart and the vascular system which feel the evil influence. I am persuaded that a very important factor in the causation of high arterial tension is the abuse—I do not say the use—of tobacco.

Another factor is, I consider, the little use that is made of plain water as a beverage in these days. Stimulants are, of course, taken in excessive quantity; this is a point conceded by all, and I merely mention the fact in passing, but scarcely any attention has been given to the negative omission of water, which is really a necessary of life. It is too often forgotten that pure water is one of the best diuretics, and is withal perfectly safe. In other words there is no more effective agent for washing toxins and impurities generally out of the blood than plain water.

It seems impossible to resist the conclusion that neglect of water drinking has a great deal to do with the marked prevalence of high arterial tension at the present day.

Over feeding is certainly a most potent cause of high pulse tension and arterial degeneration. It is by no means sufficiently recognised that after the period of growth and full development is passed the assimilative functions are no longer so vigorous as was formerly the case. After middle age the power of digestion becomes still weaker, smaller quantities of food are required, and it is of great importance to allow sufficient intervals to elapse betweeu meals. A most erroneous impression is abroad, even among educated people, that it is absolutely necessary to support their strength by frequent and rich meals; indeeed valetudinarians are often in the habit of stuffing themselves in the interval between breakfast and lunch and again between the latter meal and dinner. Sometimes they even eat during the night.

It is needless to dwell upon the harm which accrues from the overloading of the digestive system with a mass of material with which it is incompetent to deal, and the poisoning of the system which must result therefrom. In these luxurious and self-indulgent times there can be no shadow of doubt that a large number of cases of high arterial tension and consecutive renal disease are directly attributable to the prevalent gorging and stuffing, apart altogether from indulgence in alcohol.

The latter habit is so prevalent and so baneful that it is unnecessary now to enlarge upon it, but I do not believe that it sets up kidney disease, and I also hold that, as regards the production of undue vascular pressure and degeneration, chronic over-eating is chiefly responsible.

To some persons Nature has benevolently given a digestion which is extremely sensitive to excess; no matter how slight the self-indulgence may be, the least error in diet is at once resented by the stomach and intestine. A heavy and indigestible dinner is, in these subjects, invariably followed by acid dyspepsia, flatulence or diarrhœa. Such individuals often regard themselves as hardly used, for they see others committing dietetic errors of which they themselves are totally incapable, not indeed from desire, but from necessity.

Yet they little know the ultimate price which has to be paid by their apparently more vigorous brethren to whom dietetic indiscretions appear to be perfectly harmless.

The gradual onset of high arterial tension, of atheroma, and finally of chronic nephritis is the penalty paid by the seemingly more fortunate comrade.

For many persons the presence of digestive sensitiveness is a blessing in disguise; I have noticed that it is especially apt to occur in those who, by heredity, are particularly prone to gout, renal disease and high tension.

Such subjects are only too fond of good living, both as regards food, drink and smoking; yet does the chastening influence of the knowledge that indiscretion will bring its speedy punishment keep them, sorely against their will, in a healthy and active condition.

It is very often indeed the case that the small eater, the moderate drinker, and the abstemious subject generally live to an advanced age, while the seemingly far more vigorous, robust, but free living man of the world is cut off by some complication of arterial tension and degeneration long before attaining the age of 60. We are all acquainted with instances of this, and the first thing that strikes us in healthy old age is the soft and elastic condition of the arterial wall, But perhaps we still do not emphasise as we might the lessons which such observations teach us: that over-eating and over-drinking, the former as much if not more than the latter, are the most fertile causes of premature decay, senility and death in early middle age.

Of the influence of worry and anxiety it is less easy to speak positively, but it is not unreasonable to assume that the restless, excitable, high pressure life led by many people at the present day—the day of the telephone and of "tape prices"—has no small power of inducing the morbid arterial condition here considered.

That syphilis can give rise to increase of arterial tension, as part and parcel of the vascular disease of which it is the cause, is universally admitted.

The affinities of high tension and of consequent arterial degeneration are very interesting.

I have already alluded to the fact that the affection is to a very large extent hereditary, and it is here the appropriate place to point out the close alliance existing between glycosuria and diabetes, gout, chronic

degenerative disease of the kidneys and arterial sclerosis. There can be no question that all these maladies are closely allied, and this is proved by the well ascertained fact of the occurrence of these different diseases in several members of the same family. Thus it is no uncommon thing for a father to die of granular kidney, one son may succumb to the same malady, another may sooner or later present the symptoms of diabetes, a third will probably manifest evidence at or about middle age of gout and arterial degeneration, and a fourth may suffer from glycosuria. I say that it is not unusual to meet with family histories of this nature, in which scarcely a single member attains the age of 60, all being cut off by one or other of those maladies which are more or less closely allied to the degenerative diathesis now under discussion. It is not unusually held that gout or the arthritic diathesis is at the root of the evil. Rather would it appear that a hereditary tendency to degenerative changes in the vascular system, showing itself in the earliest stage by rise of arterial pressure, is that which is transmitted, and I should regard gouty symptoms and the uric acid factor generally as being subsidiary manifestations of the hereditary tendency.

I have already observed that it is of paramount importance for this tendency to be discovered and treated at the earliest possible moment. It is quite usual for it to appear during childhood, and it is not sufficiently recognised that quite small children may suffer severely from headache, acid dyspepsia, and other manifestations of a gouty inheritance with marked inclination to high tension of the arterial system. The feeding of such children requires the greatest care, and the strictest precautions should be observed as regards the admission of meat into their dietary. In many cases it should be taken in the smallest possible quantities only. Examination of the urine in such children will often show a tendency to the deposition of urates, with perhaps an excess in the quantity of uric acid passed, and in not a few instances pain and smarting in the course of the urethra will clearly indicate that the urine is concentrated and irritating.

These are the children who, when they grow up, become the victims of arterial degeneration and high tension, of glycosuria and diabetes, of granular kidney and cerebral hæmorrhage.

There can be no question as to the desirability of ascertaining the state of arterial tension in those, whether children or adults, in whom a tendency to vascular degeneration exists. This matter has been exhaustively considered by Dr. Clifford Allbutt in a paper on the "Prevention of Apoplexy." in which he points out the advisability of testing the arterial tension instrumentally from time to time, as age advances, and this in a systematic manner. This is not a refinement or a fad; it is really astonishing how easy it is to overlook an increased radial tension, and under any circumstances it is most desirable to have an actual record of the existing pressure calculated in millimetres.

I repeat that, from time to time, a routine examination by means of the Riva-Rocci or some other reliable instrument, should be made of pulse tension in all cases in which there is a suspicion of the existence of any morbid alteration of the same, whether through heredity or otherwise.

It would then be possible so to arrange the diet and the patient's mode of life generally as to avoid the risk of the morbid process going further, and attaining that arterio-sclerotic condition which it is hopeless to treat with any rational prospect of success.

As age creeps on the capillaries tend to become obliterated, and in this way arises a peripheral resistance, which in no long time induces a hypertrophy of the left ventricle, an endeavour in this way being initiated to restore the balance of the circulation.

It is only necessary to inspect the skin, more especially that of the face, in old people, in order to be convinced of the fact that the capillary circulation becomes thus obsolescent; in them the skin is thin and papery, dry and scaly; it is obviously defectively supplied with blood, being pale and hanging loosely on the subjacent tissues.

The view that arterial tension tends to increase as years advance is, I think, absolutely correct, and this increase of tension may very rapidly supervene. I have seen cases in which the pulse has been of persistently low tension for years, indeed so soft and compressible has the radial artery felt in some instances that a weakly acting, thin walled and possibly fattily degenerate heart has been thought to be present.

Yet in such a case, as the patient approached the age of 70 a rapid change took place; instead of softness and compressibility the pulse displayed the characters of high tension in the arterial system, much force being required to obliterate it. It seems to me that a comparatively sudden change such as this is of considerable clinical significance, for it is clear that a greatly increased strain is somewhat abruptly thrown on the heart, and hence signs of cardiac failure may occasionally ensue in no long time after the inauguration of the high tension.

It is impossible to over-estimate the value of pulse tension records under circumstances such as these, and it is to be hoped that exact observations may be taken respecting this undoubted increase of arterial pressure which attends advancing years.

In rare cases of arterio-sclerosis, auscultation of the head may reveal the presence of a systolic murmur. I have recognised this sound over the mastoid process, the vertex, the occiput, and the temple. In a case seen with Mr. Waggett, a loud systolic murmur was audible through the diagnostic tube placed in the auditory meatus. In practically the whole of the cases in which this physical sign was detectable there was evidence of arterial degeneration, and in most this degeneration was far advanced. In one case in which a loud systolic murmur could be heard over the vertex and occiput, *post mortem* examination revealed extreme degeneration of the aorta and circle of Willis. The inference of course is, that the systolic murmur is due to the passage of the blood over the roughened surface of the arterial wall.

It is not unusual for patients to complain of rushing noises in the head, but I greatly doubt whether these subjective sensations are really the result of the structural alterations of the arteries under consideration. In most cases in which these subjective sensations are complained of no murmurs whatever are audible in the localities named; on the other hand, so far as my experience goes, it is seldom that the patient makes any complaint of *permanent* subjective sensations of rushing noises when the murmur is evident. It is at all events clear that the subject of cephalic auscultation is one worthy of more extended observation and study; this more especially in cases in which arterio-sclerosis is known to be present. The subject is one to which little or no attention has hitherto been devoted, and yet it undoubtedly possesses an interest and importance of its own.

Much obscurity surrounds the cause of what was formerly known as "serous apoplexy." A person apparently in his or her usual health, but who is more or less advanced in years, suddenly becomes unconscious. and, if standing, falls down, perhaps inflicting a serious injury in doing so. There is total inability to rouse the patient, the breathing is stertorous, indeed the attack is absolutely indistinguishable from one of cerebral hæmorrhage. The worst fears may be entertained, and a very unfavourable prognosis may be given. Yet in no long time consciousness is recovered, and in a few days the health may be practically as before the attack. Such is the clinical history of these seizures, and very difficult is their diagnosis and prognosis. The occurrence of hemiplegia is often confidently anticipated, and lo! nothing of the kind is observed. My experience is that these attacks affect only those patients whose arterial tension is high, and very often indeed chronic renal disease with a trace of albumin in the urine is present.

It is most difficult, indeed impossible, to satisfactorily explain the cause of these attacks, but it seems reasonable to connect them to some extent with that condition of the pia-arachnoid so often met with at the *post mortem* examination of those dying of chronic Bright's disease: œdema of the membranes or some wasting of the convolutions. Whether a sudden and transitory increase of this œdema may arise and, by inducing pressure on the convolutions, may originate the unconscious condition, is a question that may be asked, but it is not possible either to affirm or deny the fact of its occurrence.

I know of no means of distinguishing between an attack of "serous apoplexy" and one terminating either fatally or in hemiplegia, except by the result.

Before proceeding to the consideration of actual cases it will be well to refer to a few details relating to pulse tension observations. As I have already mentioned I have always made use of the Riva-Rocci instrument for determining the systolic pressure. Within the limits of health it would seem that this pressure varies between 120 and 135 mm. of mercury. It is not of course possible to say that every case where the tension does not fall within these limits is one presenting an abnormality of blood pressure; as in many other conditions, the fact of idiosyncrasy must be allowed for. And it must never be forgotten that *transitory* variations of the pressure are constantly observed, being conditioned by a great variety of circumstances, such as a full meal, exertion, emotional influences, &c. But when marked changes become more or less permanent, then it may be safely asserted that tension is pathological.

It has been objected as regards the use of the sphygmomanometer in the determination of hypertension that we are already in possession of accurate means of diagnosis; in other words, the high tension pulse, the hypertrophied left ventricle and the accentuated aortic second sound are quite reliable indications of the condition. This is perfectly true, but it is forgotten that in a very large proportion of patients emphysema and obesity render it impossible for us to avail ourselves of the evidence yielded by the physical signs just enumerated.

There are certain conditions which render the use of the sphygmomanometer unsatisfactory and unreliable, indeed which preclude its employment. These are more especially œdema of the tissues at the point of application of the armlet, and coughing on the part of the patient.

In the latter case the reading invariably rises greatly, so as to be of no value, as an indication of actual pressure.

It is scarcely necessary to remark that all observations should be made under precisely similar conditions.

CLINICAL RECORDS.

FRACTURE OF THE FEMUR IN A HŒMOPHILIC.

BY KEITH MONSARRATT, M.B., C.M.EDIN., F.R.C.S.E.

Surgeon, the David Lewis Northern Hospital, Liverpool.

A BOY, æt. 8, was admitted under my care into the David Lewis Northern Hospital, Liverpool, on February 11th, 1904. Shortly before admission he had been knocked down by another boy while playing in the street. Examination showed that he had sustained a fracture of the left femur, about the centre of the shaft, oblique from behind, forwards, and downwards—as shown by the radioscopic screen, and with an inch shortening. Under an anæsthetic the deformity was corrected, and local splints with a "long Liston" were applied to the limb. During the next few days there was much swelling at the fracture site, and the boy complained of pain which kept him awake at night. On the 18th, a week after the accident, the local effusion showed no signs of disappearing, but rather a steady increase; the apparatus was changed, extension tapes were applied, the local splints were retained, and the limb was elevated to a right angle with the body axis and the extension apparatus fixed to a scaffolding over the bed. On February 21st, three days later, it was noted that no local improvement had taken place, and that the temperature had been steadily ascending by evening rises, partly sustained, up to 102° F. on this day. The local swelling was at this time definitely fluid in character, and taken in conjunction with the fever, and the great pain and tenderness of which the boy complained, it was thought probable that we had to do with a secondary inflammatory process. The chart shows that the pulse rate associated itself with the temperature, and on this day, the 21st, was 140 in the morning, 136 in the evening. When counting the pulse in the left wrist a discolouration, which appeared to be a bruise, was noticed over the radial artery, and on further examination other "bruises" were found in different parts of the body.

The next day the mother was interviewed, and we obtained the following history:—The boy had had diphtheria when eight months old, and this was accompanied by hæmorrhage from the nose and mouth. Subsequently it was noticed that he bruised very easily. He had had a tooth extracted shortly before his accident and bled for a week afterwards, in spite of firm plugging. During the last two or three years he had frequently had swelling in one or other knee; he would go to bed quite well, and wake up in the night with pain and swelling in the joint; the last attack occurred one month before admission into hospital. There was no history of a similar affection in any near relative. The mother had had three brothers; one died from "blood-poisoning" following a stab, one died from an unknown cause, the third was alive and quite healthy; the maternal uncles had also been free from any such complaint, nor did the father's family history show any hæmophilic taint.

During the remainder of the boy's stay in the hospital the diagnosis of hæmophilia was fully confirmed; bruises appeared wherever splint pressure was exerted; for example, a Thomas' knee splint which was put on on March 11th caused considerable effusion in the region of the groin when he was allowed to sit up; the appearance of the bruise from the pressure of the nurse's finger in taking the pulse shows in what a pronounced form the affection existed. Lastly, on April 28th, the left knee developed all the signs of a characteristic hæmophilic joint.

Union at the seat of fracture occurred satisfactorily and was not at all delayed; on the contrary, consolidation took place somewhat earlier than usual; four weeks after the accident it was firm, and measurement showed absence of any shortening.

I have thought it worth while to record this case because of the absence in the text-books of reference to the influence of hæmophilia on fractures. The points of importance seem to be:—

1. The local sign, the occurrence of an enormous effusion of blood around the fracture site, and the association of this with other local and constitutional signs, suggesting the inflammatory nature of the effusion.

2. The fact that union took place satisfactorily and early.

The boy is at present under treatment as an out-patient for the recurrence of the effusion into the left knee. The fever which the chart shows must be looked upon as an exaggeration of the "traumatic" fever which the great majority of cases of simple fracture exhibit. The absorption of the effusion was not associated with the presence of any unusual constitutent in the urine.

THE OUT-PATIENTS' ROOM.

KING'S COLLEGE HOSPITAL.

BY PAYTON BEALE, F.R.C.S.

CASE OF HERNIA.—Amongst Mr. PEYTON BEALE'S out-patients was a young man æt. about 18, who was complaining of a little swelling about the shape and

size of a small walnut in the right groin. His history was as follows :—When working as porter, and lifting heavy boxes he suddenly felt a sense of discomfort in the right groin. On going to bed that night he found there was a small rounded swelling in that region. He experienced no real pain, but complained of discomfort and a sensation of stretching of the tissues in the groin. He went on with his work, and during the next three days the swelling increased slightly in size until he sought advice at the hospital. On examination the tumour was found to be below Poupart's ligament, in the position of the upper part of the saphenous opening, and obviously internal to the vessels. It felt somewhat like a small elastic ball beneath the skin and superficial fascia ; it could not be reduced, there was no impulse on coughing, and the man suffered no pain when the tumour was handled, but if an attempt were made to pick it up between the fingers and thumb, he complained of a slight dragging pain, which he referred to the right iliac fossa. Mr. Beale remarked that in this region a swelling of this kind, which was dull on percussion, was in all probability one of the following :—(1) a femoral hernia containing omentum ; 2, a sub-peritoneal lipoma ; (3) an ordinary lipoma or fatty tumour in connection with the superficial fascia of that region ; (4) an enlarged lymphatic gland, one of the superficial femoral glands. The absence of pain and abdominal symptoms generally, considering that the tumour was of three or four days' duration, excluded an ordinary femoral hernia, and the definite history of its sudden appearance was, he thought, strongly in favour of its being a sub-peritoneal lipoma. He said there was no doubt that a sudden protrusion of a little lobule of sub-peritoneal fat was one of the commonest, if not the commonest, way in which a hernia commenced ; of course the real exciting cause of any protrusion from the abdomen through an already existing opening, or through an aponeurosis, was increased abdominal pressure due to sudden and violent muscular contraction, *e.g.*, coughing, lifting heavy weights, rowing, etc. As regards predisposing causes, he considered a protrusion of sub-peritoneal fat as one of the most important ; the sub-peritoneal fat either protruded through an existing opening (the internal abdominal ring, the crural ring, the umbilicus, Petit's triangle) or became suddenly pushed into some very small fissure between the fibres of the aponeurosis of the abdominal wall carrying Transversalis fascia before it. The peritoneum was of course attached to the sub-peritoneal fat (perhaps, he said, the term extra-peritoneal fat was a better one) and therefore was dragged through after the fat. The most difficult thing to explain, he considered, was the fact that the little button of extra-peritoneal fat commonly hypertrophied after its protrusion ; he could only presume that this hypertrophy was caused by increased vascularity ; but it was quite usual to find the protrusion of fat gradually getting larger and larger and so projecting outwards and dragging the peritoneum with it, thus forming a hernial sac, into which sooner or later a piece of bowel or omentum would find its way. The best treatment, he said, was to cut down upon the button of fat, ligature it, cut it off, and close the aperture through which it came as far as possible.

OPERATING THEATRES.

TOTTENHAM HOSPITAL.

OPERATION FOR FEMORAL HERNIA, ASSOCIATED WITH VARICOSITY OF THE SAPHENA VEIN.—Mr. H. W. CARSON operated on a man, æt. 42, who had been admitted to the hospital complaining of pain and swelling in the right femoral region. The patient gave three months' history of discomfort and recurrences of definite pain ; a lump had appeared within the last few weeks. The swelling had varied very much in size and disappeared when lying down. On examination the man showed some signs of muscular degeneration, the abdominal walls particularly being relaxed and somewhat protuberant below the umbilicus. Varicose veins were present in both legs below the knees, the thighs being free. In the erect position a swelling the size of a pigeon's egg was present in the region of the saphenous opening, reducible at a touch, with an impulse on coughing ; on the patient lying down the swelling disappeared entirely. When in the recumbent position the hand being placed over the site of the swelling, and the patient told to cough, a grating impulse was felt. A minute examination of the femoral ring showed the presence of some slight thickening which was taken to be the empty sac of a femoral hernia. A vertical incision was made over the saphenous opening, the large varicose saphena vein was readily isolated, and a portion about two inches long removed between ligatures. Lying close to the vein and in front of it was a thin sac, which on being opened proved to be the sac of a hernia. The neck of the sac was transfixed with a ligature which was tied, the ends being left long, the sac being then cut away. The ends of the ligature were next threaded on the herniotomy needle, which was passed up the femoral canal, and brought out through the abdominal wall as high as possible. The femoral canal was then closed by attaching Hey's ligament to Cooper's ligament (the thickened upper portion of the pectineal fascia), by two silkworm gut sutures and the wound closed by continuous silk suture. Mr. Carson said that this case was interesting because of the association of two conditions which were frequently difficult to differentiate : the diagnosis of varicosed saphena vein from femoral hernia was sometimes very puzzling ; both conditions gave rise to a swelling in the femoral region ; in both cases the swelling was readily reducible and gave an impulse on coughing ; in both cases the patient was generally middle-aged and often gave signs of muscular degeneration. The points of difference were these :—In a varicosed saphena vein, varicose veins could always be found elsewhere in the limb, generally below the knee, the thigh being free. This made it necessary, in examining, these cases, not to be conten with an exploration of the femoral region only. With regard to the reducibility, the swelling in varicosed saphena disappeared at a touch and became non-existent at once on the patient lying down. The impulse on coughing was characteristic. The forcing of the blood back from the external iliac vein caused a curious rough grating feeling which was absolutely unmistakable. There was only one hernial condition, he said, which gave rise to an impulse at all similar to this, namely, an omental hernia with a little fluid in the sac. With regard to the operation, Mr. Carson considered that the method adopted of joining Hey's ligament to Cooper's ligament gave the best prospect of closing the femoral canal at its abdominal end. In passing the sutures it was necessary to avoid injuring the femoral vein which lay just to the outer side. In transplanting the neck of the sac it must be remembered, he pointed out, that in men the vas deferens might be injured in the act of piercing the abdominal wall from within outwards. With reference to the result of radical cure in femoral hernia, Mr. Carson said that with few exceptions femoral hernia was an acquired condition, that is to say, it resulted from slackening and yielding of the abdominal wall following upon muscular degeneration. One cannot therefore, he remarked, hope for as good results in these cases as one would expect to get after a radical cure of inguinal hernia, which last, however, should only be done, in his opinion, as a curative measure in cases in which there is no evidence of muscular degeneracy.

TRANSACTIONS OF SOCIETIES.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD JULY 4TH, 1906.

Dr. J. O. AFFLECK, President, in the Chair.

MR. F. M. CAIRD showed (1) a large vesical calculus and prostate removed by operation; (2) a number of preparations illustrating perforated gastric ulcer.

Dr. ALEXANDER BRUCE showed (1) two brains containing large tumours involving the pituitary body without acromegaly having resulted; (2) a brain from a case of chronic chorea; (3) a brain with thickened vertebral arteries involving both spinal accessory nerves; (4) heart from a case of mitral stenosis, with a large spherical vegetation almost totally occluding the mitral orifice; (5) heart with ulcerative endocarditis, showing a large vegetation on the ventricular aspect of the aortic cusp of the mitral valve; (6) microscopic specimens from the same case, showing bacilli from the cerebro-spinal fluid and blood drawn during life, and from the vegetation; (7) photographs of partial ophthalmoplegia.

Dr. H. M. CHURCH showed Gärtner's tonometer, and gave a demonstration of its mode of employment, as well as the results he had obtained from a series of investigations with it under different conditions of health and disease.

Dr. KEPPIE PATERSON read notes of a case of

RUPTURED GASTRIC ULCER

in a boy æt. 12 years. The patient had had no previous illnesses, with the exception of a tendency to laryngeal spasm whenever he took a cold. For twelve days before the onset of his illness he had suffered from indefinite dyspeptic symptoms—epigastric pain coming on at periods varying from a half to two hours after food, but no vomiting. At about 7 p.m. one evening, just after dinner, he was suddenly seized with violent pain in the abdomen and under the left clavicle, and became collapsed. He was pallid, the pulse was slow, the abdomen was tender and resistant, and the liver dulness was normal. The pain was greatly relieved by hot fomentations, and he passed a fairly good night, though disturbed by retching. When seen next morning there was evidence of commencing peritonitis, the abdomen being distended and tender, and the liver dulness abolished. A diagnosis of perforation of one of the abdominal viscera was made and operation was decided on. On opening the abdomen a perforated ulcer about the size of a split pea was found on the anterior wall of the stomach about two inches from the middle of the lesser curvature. This was sutured and the wound closed. The patient was fed by the bowel for three days, by the mouth and bowel for two days more, and by the mouth only from the sixth day. On the third day signs of pneumonic consolidation of the right lung appeared and spread quickly over the whole of that half of the chest. By the seventh day the patient was extremely cyanosed, and on the following morning the pneumonia was found to have invaded the right lung. The boy was critically ill for several days, being unconscious and much distressed by a recurrence of the largyngeal spasm to which he had always been liable. His temperature ultimately fell by lyses and he made a good, though tardy recovery. Oxygen inhalations had been of the greatest benefit. Dr. Paterson gave a short *résumé* of the reported cases of perforatory gastric ulcer in children. He had only been able to find records of 14 in persons under fourteen years; of these, one only had been diagnosed during life. In his patient he had been unable to discover any cause for the ulcer having developed.

MR. F. M. CAIRD read a paper on

TWENTY-FIVE CONSECUTIVE CASES OF OPERATION FOR PERFORATING GASTRIC AND DUODENAL ULCER.

Fifteen of these occurred in females and ten in males. In most cases there was a prior history of dyspepsia, vomiting having occurred in nearly half the patients. A history of hæmatemesis or metæmia was only exceptionally met with—a common experience in series of cases of perforated gastric ulcer. As regards the symptoms of perforation, pain was invariable; in many instances it was referred to the left shoulder as well as to the epigastrium. Vomiting occurred in 18 cases; there were often some of the signs of obstruction—constipation, distension, and absence of the passage of flatus. The liver dulness was almost always absent. On examining the abdomen it was always found to be rigid; tenderness was chiefly marked at the epigastric and suprapubic regions. The respiratory movements were usually diminished or absent. On rectal exploration tenderness and fulness could generally be made out in the pouch of Douglas; no pain attended micturition. After perforation had taken place the symptoms of collapse developed, and the temperature, pulse, and respiration gradually rose. In seven cases in which the blood had been examined there was a leucocytosis varying between 7,000 and 25,000. In operating it might be possible to perform the preliminary steps of opening the abdomen under cocaine, but for the necessary intra-abdominal manipulation a general anæsthetic would be required. On opening the abdomen the anterior aspect of the stomach ought first to be explored, carefully removing masses of lymph, which lay around the orifice of the perforation. If the liver sac was found to be distended with fluid, the ulcer was probably on the posterior wall, and it was necessary to divide the gastro-colic omentum so as to gain access. Having found the ulcer, and temporarily plugged it with gauze, the next step was to make certain that there was not a second perforation. It was seldom advisable to excise the ulcer; a double Lembert suture was amply sufficient to close it, and if, as was sometimes necessary, so large a part of the stomach wall had to be invaginated that the operator dreaded a future stenosis, a gastro-enterostomy should be performed after the ulcer had been sutured. The upper part of the peritoneum should be cleansed either by irrigation or gentle swabbing, and need not be drained. A suprapubic drain, however, ought always to be passed into the pouch of Douglas, and the head of the bed kept raised so as to facilitate gravitation of effused fluid into that neighbourhood. In his series of cases the perforation had taken place in the anterior wall of the stomach in 18 cases, in the posterior wall in 4, and on the anterior aspect of the first part of the duodenum close to the pylorus in 3. The diagnosis of perforation was not always simple, and he had on more than one occasion opened the abdomen without finding anything to account for the symptoms. The prognosis depended largely on the virulence of the bacterial infection of the peritoneum combined with the power of resistence of the patient. Happily the organism was as a rule of low virulence, as the acid gastric secretions inhibited their growth. Staphylococci was commonly found, and sometimes, when the intestine had been damaged, b. coli. In 7 out of 11 occasions on which cultures had been made this organism was found; in the remaining 4 the tubes remained sterile. The prognosis also depended to a large extent on the period at which the operation was performed, and particularly on the pulse rate. The largest recovery rate occurred in patients in whom the pulse remained under 120, while in those in whom it was over 130 the death rate was very high. With regard to after treatment, transfusion should be freely resorted to

when the pulse flagged, and might be repeated several times if need be. Thirst was best quenched by large rectal salines, Vomiting could be checked by washing out the stomach. Among the complications occurring in individual cases pleurisy, empyema, and bronchitis were the most frequent. One patient developed a fatal cerebral abscess as a sequela of empyema. One patient was twice operated on for perforation. On the first occasion a commencing hour glass contraction of the stomach was found; at the second operation a year later the constriction had increased so much as to make it advisable to perform a gastro-enterostomy.

Mr. ALEXANDER MILES read some observations on PERFORATED GASTRIC AND DUODENAL ULCER, BASED ON A PERSONAL EXPERIENCE OF FORTY-SIX CASES OPERATED UPON.

We hope to publish a report of this in our next.

THE SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

THE Provincial Meeting of the Society was held at the Radcliffe Infirmary, Oxford, on June 23rd.

Dr. OSLER was in the Chair during the exhibition of clinical cases and pathological specimens, and Dr. W. COLLIER (Oxford) for the Papers.

Mr. A. P. PARKER (Oxford) exhibited a boy with dislocation of both patellæ outwards.

Mr. H. P. SYMONDS (Oxford) exhibited a girl with a solid tumour of the pelvis, probably enchondroma.

Dr. W. J. TURRELL exhibited a well-marked case of achondroplasia in a girl.

Dr. E. MALLAM exhibited a child with enlarged liver and spleen for diagnosis.

Dr. E. MALLAM exhibited three cases of calf ringworm, and Miss FITZGERALD showed microscopic specimens and cultures from these cases.

Mr. PERNET also exhibited cultures of ringworm from the scalp and nails.

Mr. P. H. ADAMS exhibited a case of lamellar cataract, who also suffered from icthyosis simplex.

Mr. FINCH exhibited a well-marked case of cretinism in a child.

Mr. R. H. A. WHITELOCKE exhibited a girl with double hernia of the ovary, whose sister had suffered from the same trouble and from whom one ovary was removed by operation and reported at a previous meeting of the Society.

Mr. C. P. PARKER exhibited a specimen of congenital malformation of the intestines in a full-time fœtus, In this specimen the stomach was normal, but the duodenum was enormously distended and at the duodeno-jejunal flexure there is complete occlusion of the tube of the gut, and the rest of the intestine lying in a corkscrew manner with a small mesentery.

By permission of Professor JAMES RITCHIE, numerous pathological specimens were exhibited, viz., Cirrhosis of the Liver in a child, æt. 10. Granuloma of the Brain with Nodules in the Lungs. Tuberculoma of the Brain and Tumour of the Choroid Plexas.

By permission of Professor THOMPSON numerous anatomical specimens were exhibited, (1) illustrating the development of the thymus at various ages; (2) the sexual differences of the pelvis in the fœtus at birth; (3) the lobulated condition of the kidney at birth; (4) the appearances of the ovary at birth and subsequently.

Dr. GEORGE CARPENTER read notes of a case of acute osteomyelitis of the spine in an infant. A girl, æt. 1, was admitted into the North-Eastern Hospital for Children. She looked ill, was anæmic and somewhat wasted. In the left loin there was a large smooth rounded and fluctuating swelling, dull on percussion and very tender. The child died six days after admission. *Post mortem*.—The left pleura contained about two pints of purulent fluid. In front and to the left of the first, second, and third lumbar vertebræ there was a quantity of pus, and the cavity communicated with the left pleura. Microscopical examination of the pus showed streptococci and diplococci. No tubercle.

Dr. E. C. WILLIAMS read some notes of a case of congenital heart murmur in an infant, æt. 5 months, during an attack of whooping cough.

Mr. H. P. CROLY read notes of a "Case of Intussusception," in an infant, æt. 9 months, successfully operated upon by Mr. Whitelocke at the Radcliffe Infirmary. The operation took place eight hours after the first symptom, and was of the ileo-cæcal variety.

Dr. BERTRAM ROGERS read notes of a case of "Acute Atrophy of the Liver," in a boy, æt. 4, admitted into the Bristol Children's Hospital. The child's only previous illness was measles. When first seen he was distinctly yellow and was very sick and complained of abdominal pain. He became delirious and in lucid intervals complained of headache, the jaundice was now well marked. He died two days after admission *Post mortem*.—The liver was about the usual size, and no obstruction to the flow of bile.

Dr. A. G. GIBSON read a paper on some observations on

ENLARGED VEINS IN CHILDREN.

He remarked that a large proportion of children brought up to the out-patient department of any hospital suffer from loss of appetite, wasting, and general debility. Physical signs are, as a rule, few. In many of them, however, veins in various situations are more easily seen than in normal children. The commonest situation is on the front of the Chest, but they are found frequently on the back between the shoulder blades, under the chin, and on the temples. The veins are exceedingly small and are flush with the surface of the skin. These venous ramifications are not seen in all thin children, as, for instance, in the wasting that results from a cerebral tumour; hence it is probable that these veins are dilated. That in some there is venous obstruction is shown by the presence of dilated external jugular veins on one or both sides, even in the upright position. On deep inspiration they do not collapse as do jugular veins in other subjects, *e.g.*, a patient breathing deeply under an anæsthetic. Accurate records have been kept of fourteen such cases, showing as the cardinal sign dilated jugulars on one or both sides, which do not collapse on inspiration. Of these, seven were male and seven female; the age varied from four to ten years; a history of tuberculosis in the family was obtained in eight cases; the symptoms were either lassitude or wasting, or referred to the digestive or respiratory systems such as frequent attacks of vomiting and diarrhœa and attacks of bronchitis or some form of chest trouble. The left jugular vein was enlarged in fourteen, the right in twelve, veins on the chest were visible in thirteen cases, on the back in two, under the chin in two, on the temples in seven. Downy hair on the back was found in six cases. The retraction murmur of Eustace Smith in ten. Small glands in the neck or elsewhere were present in nine cases. Tuberculous peritonitis was present in two cases, while in a third the signs suggested a similar condition. Only in one case has it been possible to observe the anatomical condition under which the dilatation of the veins is produced. This was in a case of tuberculous peritonitis in which a dilated left jugular vein had been noticed for some time previous to death. A dissection of the anterior mediastinum shows a ring of small fleshy glands surrounding the left innominate vein. Sections made from one of the glands show a few giant cell systems and tubercle bacilli. The posterior mediastinum in this case shows several hard caseating glands with large numbers of tubercle bacilli. The cases correspond in character to those described by Eustace Smith as being due to tuberculosis of the mediastinal lymph glands, and without implying that dilated jugular veins which do not collapse on inspiration are pathognomonic of such condition, it is suggested that in the presence of a tuberculous history symptoms of debility, small glands in the neck, veins on the chest, back, neck, or temples, a retraction

murmur; and in the absence of signs pointing to syphilis, lymph adenoma or lymph sarcoma, the sign may be of value in the diagnosis of early tuberculosis.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, July 8th, 1906.

CHRONIC URETHRITIS OR GLEET.

THE persistence of a few drops of pus escaping from the meatus in the morning is a constant relic of gonorrhœa. This gleet constitutes a symptom of the decline of the malady, not of its cure. Urethritis that has become chronic, says Dr. Pillet, is one of the most tenacious affections of the urinary apparatus. Hence the importance of an early and methodic treatment. The anterior portion of the urethra is always affected, not so the posterior portion. By its integrity or contamination can be judged the curability of the gleet. In order to be clear on the question it is necessary to ask the patient if he has had in the course of one or more attacks of blenorrhagia, orchitis, or cystitis, proofs of posterior infection. The different portions of the canal, perineal, scrotal, and penine should be pressed strongly from behind forwards in the endeavour to squeeze a drop from the meatus. This operation will rarely succeed, however, as the patient has generally urinated beforehand, thus washing out the canal. No other exploration should be attempted at this examination; the passage of a bougie or catheter is dangerous, as it might carry the infection to the posterior portion, up to that time healthy. Two microscopic plates will be given to the patient to receive a drop of the gleet and he will be invited to return next morning without having previously urinated.

Immediately the practitioner will endeavour to find out if the anterior portion alone of the urethra or the two are infected. For this examination there are two methods:—

First, that of two glasses, according as the first only or both contain deposits. The second method is more exact: the glands having been washed with a solution of oxy-cyanide (1–100), the urethra washed and the bladder filled with a solution of ½-1,000. The first day the first jet of urine is collected after massage on a bougie of the anterior portion of the urethra. The second day, the second jet is collected after massage of the posterior portion and the prostate. The microscope will terminate the examination. If the second glass presents white filaments floating through an otherwise limpid urine, the posterior portion of the canal is certainly infected, but the microscope alone will give a correct diagnosis and indicate the proper treatment.

This treatment consists in large irrigations of the urethra with a solution of permanganate of potash, or, better, oxycianide at ½-1,000 and instillations of a solution of nitrate of silver (1-100) into the posterior portion of the canal by means of the special instruments used for this purpose—a catheter with enlarged extremity and a syringe. Care should be taken not to penetrate into the bladder or to use force in injecting the solution.

The instillations should be practised two or three times a week and the patient should be informed that the first injections far from diminishing the gleet, provoke on the contrary some secretion.

The gonococci persist sometimes, in spite of the most active treatment.

Every fifteen days irrigation of the urethra will be made with the oxycyanide solution, while a drachm of the following solution will be injected into the canal twice a day.

Oxygen water	1 drachm;
Distilled water	3 ounces.

The injection will be kept in from one to three hours by surrounding the glands with cotton-wool tightened by a ligature.

Dr. Pillet says he has seen gleet get well by this method (somewhat painful) that had resisted every other means.

Marriage may be permitted in spite of the persistence of a few filaments, if gonococci are no longer found.

In women it is impossible to affirm the disappearance of the bacilli. Coitus should be preceded by an injection of corrosive sublimate in the female and miction in the male.

THIOSINAMINE.

Thiosinamine has been much recommended for the treatment of cicatrix produced by burns by water or caustics. It is used hypodermically, either beneath the skin of the back or into the muscles of the gluteal region. But it is more effectual when injected into the veins. Its field of action however is not limited to superficial cicatrix; it seems to act with advantage on parametric and pleuritic adherences.

A very successful case is reported in one of the medical journals. A man had a stricture of the œsophagus from swallowing a secretion of caustic soda. For some time a sound was passed, but finally it had to be abandoned and liquids would no longer pass. A gastric fistula was made, by which the patient was fed, but he continued, nevertheless, to waste away. At this point injections of thiosinamine were tried. Half a syringe of the following solution was injected into the forearm and repeated every five days.:—

Thiosinamine	½ drachm.
Glycerine	2 drachms.
Distilled water	3½ drachms.

After the third injection a small sound passed with great facility, and the patient was able to swallow liquids. A fortnight subsequently a much larger sound passed, and at the end of a month the patient took solid food.

GERMANY.

Berlin, July 8th, 1906.

AT the Freie Vereinigung der Chirurgen, Hr. Cohn spoke on

X-RAYS IN MALIGNANT DISEASE.

He had treated a number of malignant tumours with the Röntgen rays; the most suitable for the treatment were lymphomata and lymphosarcomata. Of five cases treated in this way, three recovered, one of them fifteen months ago. In some of the cases the tumour was removed and examined microscopically, and the diagnosis thereby confirmed, but recurrence took place rapidly and it was these recurrences that were treated with the rays. A recurrence of a sarcoma of the parotid had disappeared after fourteen days of the treatment. Success in carcinomata was by no means so certain, but even in these cases success was obtained here and there in ulcerated and sloughing cancer of the breast, where cicatrisation was successfully brought about.

Hr. Hermes described four cases of

ILEUS FROM GALL STONES.

Only two of the cases had had colic previously, the other two had never been ill before. In one there was already a deep ulceration of the abdominal wall above the calculus. Death took place in this case, a proof that operation was too long delayed.

Lumbar anæsthesia was successfully carried out in these operations and proved very successful. Of course, the danger of general narcosis was avoided; there was also another advantage in the setting up of active contraction of the intestines.

Hr. Neumann had operated on three cases in the last three years. He considered it more correct to make a transverse incision into the bowel than a longitudinal one. In one case he found a congested intestine with glistening serosa in the region of the groin, but concluded that the part would recover itself. Some days later a fresh ileus broke out, the cause of which was attachment of the congested part and not of the line of incision, which had caused a kink. Recovery took place.

Hr. Sonnenburg spoke on the

VALUE OF COUNTING THE LEUCOCYTES.

He was of opinion that although at present but little reliance could be placed on such counting, it ought to be systematically carried out in the hope and expectation that from a large accumulation of facts valuable conclusions might be drawn at some future date. He showed a large series of curves from which, however, no conclusion of value either as regards prognosis or diagnosis could at present be drawn. Most of the curves were taken from cases of appendicitis.

Hr. Karewski was of opinion that such counting might under certain circumstances be actually misleading.

Hr. Martens believed that an increasing number of leucocytes pointed to a hidden abscess.

Hr. Sonnenburg, in reply, observed that the symptoms as a whole, must be considered, the number of leucocytes included, but that one symptom alone must not be relied on, any more than any other single one.

Dr. Fr. Kirchberg gives a report in the *Aerzt-Sachverst-Zeitung* on twenty-four cases of

ATTEMPTED SUICIDE WITH LYSOL.

observed in the *2nd Medical Klinik* of the Charite Hospital during the last two years. All the other attempted suicides by poison during the same period, have been 22, of which 10 were by sublimate with a fatal result in four cases. Lysol has only lately been put on the Poison Schedule, so that up to quite recently it was readily procurable.

Out of the 24 attempted suicides, only 2 were successful. In other tables the mortality has reached as high as 50 per cent. One reason for these favourable hospital statistics is that where the poison proves fatal it does so with such rapidity that the patients are dead before they can be sent to a hospital, whilst a large proportion of those who live long enough to reach it survive. The symptoms of lysol poisoning are: loss of consciousness, which may come on in a few minutes, or may be delayed for hours, vomiting (rare), smallness, irregularjty, and acceleration of pulse, interference with respiration, which is superficial and slow, or may be accelerated and irregular, almost constant cauterisation of the mouth, chin, neck, throat and œsophagus. Burning in the throat, difficulty of swallowing, hoarseness, but much pain is rare. Black to olive green colourations of the urine with phenol ferric-chloride reaction.

The diagnosis is easy from the expired breath, and the brown cauterization of the external parts.

The prognosis when the first great danger from collapse and somnolence is over is moderately favourable It is difficult to name a fatal dose, so much depends on the organisation of the individual; it also matters much whether the poison is taken on a full or an empty stomach. This explains why it happened that whilst some escaped with life after taking 100 ccm. of pure lysol, others with an empty stomach succumbed to much smaller quantities.

The treatment consists in emptying the stomach as quickly as possible with the stomach pump and washing it out thoroughly. The washing out must be continued until the returned water is no longer milky, and has lost all its lysol odour. If a long time has elapsed since the attempt and the stomach was empty, magnesia usta should be given for the formation of insoluble compounds. Camphor should be given for the cardiac weakness. The after treatment consists in the administration of fluid mucilaginous diet, and in watching the cardiac function.

It was interesting to note that the voluntary suicides were almost all young women who had attempted self-murder frequently from the most trivial causes, apparently. The writer proposes from a practical point of view that a commission be appointed consisting of medical men and pharmacists who shall have the power to put newly invented poisons on the list at once, as they come out, and without waiting for them to kill a number of people before their unrestricted sale is prohibited.

AUSTRIA.

Vienna, July 8th, 1906

GANGRENE OF THE SKIN.

NOBL showed the members of the Gesellschaft a patient, æt. 20, who about the end of May last year came to hospital complaining of a burning red vesicular rash on the left side of the thorax. The vesicles ranged from the size of beans to a fine miliary with red areola at the base. Twenty-four hours after the contents of the vesicles changed to a gluey consistence leaving a fibrinous scale which soon assumed a gangrenous appearance. Hysterical symptoms accompanied the eruption, such as hemi-anæsthesia on right side of thorax and face; a slight pressure on the mammæ gave great pain. A few days later the eruption reappeared on the opposite side extending down the arm and accentuated in the arm-pit, which became confluent, this time leaving behind a glossy, moist, necrotic centre.

On June 7th she was transferred to the Stephanie hospital, where a new outbreak of the rash appeared. Fourteen days later she was dismissed with deep scars on the body where the vesicles had been.

Three weeks later she returned with the rash more widely diffused over the left side and right leg. She was subsequently kept under close supervision with no better results; the rash still repeats itself, leaving large confluent gangrenous patches on arms, breast and shoulders.

There is nothing in her history worthy of note except an accident which occurred to her while cleaning a garment, when a needle ran into the palm of her right hand, and was removed in fragments. This accident occurred three years before the first appearance of the rash, and can hardly be connected with the eruption. Speigler and Weinlechner thought the origin of the rash was artificial in nature.

Nobl assured the members that every possible care was taken to eliminate this factor, and thought with Kreibichs that the morbid origin was an angio-neurotic inflammation.

SCLEROTIC PENIS.

. Ehrman exhibited a preparation taken from a sclerotic penis in which the spirochæte was distinctly present lying in the sheath of the nerve and nerve substance itself This is another confirmation of his theory that all syphilitic changes in the tissue are associated with the spirochæta. He has always found them present in neoplasms of the muscles and nerves, and more recently in all infiltrations due to the syphilitic virus. He has met with them in the Pacinian bodies as well as the fine capillaries. Hitherto the presumption has been accepted that the spirochæte existed in such cases in the fibrous and cellular tissue, but when it disappeared thence no syphilis was assumed to be present. Closer examination of the subject teaches us to assume that the virus has penetrated deeper to the muscles and nerve-structures as presented to us in these sclerotic infiltrations. What the destiny of the spirochæte is after it reaches the nerve structure we cannot say, but patience will no doubt solve the riddle. Here we have it persisting in the Nervus pudendus, and may find it later passing hither to some of the other large trunks. This may lead to a better explanation of many of the sequelæ of the syphilitic, virus, such as tabes which usually commences in the lower part of the cord agreeing with the ascending nature of the spirochæte from the pudendic nerve to the spinal column, where we may hope to find the microbe at a later period of the patient's history.

CONTINENTAL HEALTH RESORTS.

[FROM OUR OWN CORRESPONDENT.]

I.—AACHEN (AIX-LA-CHAPELLE).

BOTH names of this ancient spa evidently evolved from its mineral waters; the German Aachen coming from the Celtic *Ahha*, and the French Aix-la-Chapelle from the Latin *Aquæ*, joined with a recognition of Charlemagne's Cathedral, the site for which was

doubtless chosen here because of benefits the Grand Old Monarch obtained from its hot springs.

Few traces of Celtic days exist; and the remains of Roman baths are not remarkable. The place apparently owes most of its ancient renown to the Carlovingians, Pepin occasionally residing here, and Charlemagne making it the Capital of his Empire. He was crowned at Aix-la-Chapelle, as was his son Louis; and in later years thirty-two other German Kings had their coronations in the church of Charlemagne, to which he had given relics highly venerated during the Middle Ages.

Situated near the frontiers of Germany, Belgium, and Holland, Aix-la-Chapelle is very accessible from many countries. From London, the transit is not more than eleven hours (by various routes); from Paris, eight hours only. It lies in a valley surrounded by high hills, mostly well wooded, and is thus thoroughly protected from unfavourable winds. Three picturesque heights, Lonsberg, Wingartsberg, and Salvatorberg, are located in the valley of the town, and close to the city limits are forests, rich in foliage, and having elevations commanding superb views.

The mineral springs issue from two strata of Devonian limestone, and are found in parallel courses running from south-west to north-east; the outflow reaching the great quantity of over 1,100,000 gallons (minimum) every twenty-four hours. Their temperatures range from 38° to 77° C.; one of them is the hottest of European Springs, exceeding in temperature the "Sprudel" of Carlsbad.

Although these Springs are divided into two groups at the surface of the ground, they are manifestly flowing from a common origin below the surface; for whatever lowers the level of either group, also similarly lowers the level of the parallel group.

In the *Superior Group*, the most famous Spring is the Kaiser, supplying the "Kaiserbad" (of ancient renown), the "Queen of Hungary Baths," and the "Neubad." Its waters are also conveyed to the Fontaine Elise, opposite the popular Nuellens' Hotel. The Kaiserbad itself is in the basement of "The Kaiserbad Hotel," and has a temperature there of 55° C.

The baths of the Quirinus Hotel obtain their supply from three other sources of the "Superior Group."

In the *Inferior Group*, the Rose Spring supplies the "Rosenbad," and the "Comphausbad," and partly also the fine "Corneliusbad," which likewise has a separate source of supply from the Cornelius Spring.

In the Burtsheid suburb is another group of twenty-eight springs, amongst them being the Muhlen, Schwert, Fontaine, St. Michel, St. Jean, Rosen, and St. Charles.

The analyses of the Kaiser Spring Water show (in 10 litres):—

Iodide of sodium	0.005
Bromide of sodium	0.031
Sulphuret of sodium	0.111
Chloride of sodium	26.394
Chloride of lithium	0.033
Sulphate of soda	1.527
Sulphate of strontium	0.0025
Bicarbonate of soda	9.186
Bicarbonate of magnesia	0.771
Bicarbonate of lime	2.274
Bicarbonate of Protoxide of Iron	0.131
Silicic acid	0.661
Organic matter	0.084

In 10 litres of Kaiser Spring Water are absorbed:—

Nitrogen	127.8 ccm.
Carbonic acid	1269.4 ccm.

Carburetted hydrogen-gas—

Methan	5.2 ccm.
Oxygen	17.6 ccm.

100 volumes of the gases rising from the Kaiser Spring consist of:—

Nitrogen	66.98 per cent.
Carbonic acid	30.89 ,,

Carburetted hydrogen gas—

Methan	1.82 per cent.
Sulphuretted hydrogen gas	0.31 ,,

The Aix-la-Chapelle treatment combines usually drinking of the waters with the use of baths; as the plain bath, the douche, and the vapour baths. These baths are placed on the ground through which the hot spring water runs; consequently, however prolonged the bath-treatment may be, no part of the bath-room can possibly become cool.

The douche treatment here is especially effective, and superior to any other on the Continent. Jets of water of even temperature, and of 5mm. to 9mm. in diameter, (at the precise degree of heat and of the exact force as prescribed in each individual case by the physician), are applied to the back, the limbs, or the other specified parts of the patient, accompanied with systematic rubbing, and gentle massage. *This is done in the bath itself, and not as customary elsewhere in a separate room.*

At Aix-la-Chapelle, the Doucheur, or the Doucheuse, descends with the patient into the empty bath, and supplements by kneading and massage the action of the douche, *while the bath is filling with water.* The patient, therefore, need not leave the douche-room to get his bath, and remains longer in the bath after the douche to assist and prolong its effects. The irritation of the skin, produced by the hot-waters and massages, continues to develop itself, as is shown by the redness of the skin and efficacious perspiration. All the Douchers and Doucheuses must have passed Government examinations, and under their skilled treatment the Aix-la-Chapelle douche is a very efficient and quite an agreeable application. It has a remarkably alterative effect, causing the absorption of traumatic and gouty exudations; its influence is notable in the decreased weight of the patient in the early stages of the "Cure," and the increased excretion of uric acid. urea, chlorides, phosphoric acid, &c. The elimination (in the joints, tissues, and skin) of uric acid is particularly manifest.

In a subsequent article will be mentioned the diseases for which the Aix-la-Chapelle "cure" is specially indicated.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

HEALTH OF EDINBURGH. SIR HENRY LITTLEJOHN'S ANNUAL REPORT.—The birth-rate for the year 1905 was 22.99 per thousand, the lowest yet recorded. It has fallen almost steadily since 1879, sinking below the mean rate of 28.8 in 1890. Edinburgh compares very unfavourably with the large towns in England and Scotland as regards birth-rate, and is indeed only surpassed in this respect by Bradford, with 21 per 1,000. Of the total births, 7.5 were illegitimate. The death-rate for the year was 16.25, or, excluding those among persons from the country who were merely temporary residents or had come to the city for treatment in one of its medical institutions, 14.23 per 1,000. This is the lowest figure yet attained, and as the death-rates of the last five quinquennia show 18.23, 18.26, 18.17, 17.48, and 15.6, is not accidental, but in consonance with a continuous reduction which has taken place during the last twenty years. The highest mortality (20 per 1,000) occurred during the last week of January; the lowest (10.3) during the last week of September. The zymotic death-rate was below the average for the previous five years—.99, as against 1.22. Only two cases of small-pox occurred, with no deaths, and only one case of typhus. Measles accounted for 103 deaths, or .3 per 1,000. Scarlet fever is apparently much less virulent in type than during some years past, the mortality having diminished to a much greater degree than the number of cases notified. Enteric fever accounted for 20 deaths, or .05 per 1,000. Only 9 deaths were ascribed to puerperal sepsis, as opposed to 11 in the preceding year. A special feature of this year's report is the prominence given to the work of the City Hospital. It is of interest to note, from Dr. Ker's memorandum, that of the 230 nurses and servants

attached to the hospital and exposed to infection, only 11, or 6 per cent., contracted disease, and all made good recoveries. As regards the admissions for diphtheria, attention is drawn to the fact that many cases are sent in on a bacteriological diagnosis, which ten years ago would not have been considered to have diphtheria at all. Sir Henry doubts whether the discovery of the bacillus always justifies a diagnosis; on the other hand, it is obvious that the isolation of such cases is for the public good. Of cases of true diphtheria, 8.4 per cent. developed post diphtheritic paralysis—a smaller proportion than usual, but as against this the cases of membranous croup, or laryngeal diphtheria appear to have been of a much more severe type than in previous years. More than half required operation, intubation being the method of election. Surgical interference, however, is best postponed as long as possible to give the patient any chance with antitoxin. The percentage mortality of all operations was 35 per cent.; of intubation 33 per cent.; and of tracheotomy, 40 per cent. The importance of early injection of antitoxin is brought out by the fact that of 20 cases treated on the first day none died; of 141 treated within forty-eight hours, 4.23 per cent. died; of 238 cases, infected in the second forty-eight hours, 8.42 per cent. died, while of 109 cases infected on or after the fifth day, 15.927 died. The enteric death-rate was very low—6.8 per cent.—probably because so large a proportion of the patients were children. Under the head of scarlet fever, reference is made to the fact that an unusually large number of cases which appeared typically septic on admission, was not ultimately classed as such. This was due to the very rapid improvement which was manifested within a few days of admission—improvement which is ascribed to the large cubic space per bed and the extremely ample ventilation of the new hospital. Considerable success has also been attained by treating these cases in the open air, on balconies. As usual, the report is replete with graphic tables and charts emphasising the points in the text; it is full of interesting statistical material.

WOMEN GRADUATES AND THE FRANCHISE.—Lord Salvesen has given his decision in this case in favour of the Universities and against the claims of the women. Judgment was based on the broad,and, as it seems to us, unassailable ground, that a constitutional question, such as is involved in the enfranchisement of women, could not be decided by the interpretation of what is more or less a side issue in an Act of Parliament.

GLASGOW.

CASES OF CEREBRO-SPINAL MENINGITIS continue to crop up in various parts of Glasgow, although the most of them are from the East End of the City. There have, up to the present time, been over sixty cases, and the death-rate has been appalling, inasmuch as no case that has been removed to hospital has recovered. The majority of the patients are under ten years of age, and quite a number even below the age of one year. Most of the deaths have taken place within one week of onset. The premonitory symptoms of this disease are often vague; the child is out-of-sorts, and cannot tell what is the matter. The mother may blame its stomach, as vomiting may be an early symptom. Then in a few daysthe nervous storm may burst, and the child be seized with convulsions, terminating in coma and death. The retraction of the head is a marked feature of the disease, the child presenting the appearance of one bridging in "catch-as-catch-can" form of wrestling. After death, a purulent exudate is generally found in the membranes of the brain and spinal cord, and this inflammation is directly associated with the presence of the diplococcus of Weichselbaum.

STAFF CHANGES AT THE ROYAL INFIRMARY.—There have been a good many changes in the staff of the Royal Infirmary. Several physicians and surgeons have retired on the age limit, and the younger men promoted. Lately, however, the ordinary precedent was set aside, viz., that of elevating the junior men on the staff to higher positions. Dr. John M. Cowan, who has been working in the Western Infirmary, has been selected as physician to the wards, vacated by Dr. Allen. Dr. Robert Ramsey has been appointed a dispensary surgeon.

POST OFFICE MEDICAL OFFICERSHIP, GLASGOW.—This office, rendered vacant by the death of Dr. Dongan, is about to be dealt with by the authorities on a new system. It is proposed to divide the area into districts and to appoint a local practitioner, paid by a capitation grant, to each. Heretofore the arrangement has been to have one medical officer only, who devoted his whole time to the work. Very properly, those selected will be required to give an undertaking to attend personally to all post office patients.

BELFAST.

PUBLIC HEALTH.—At the monthly meeting of the Corporation held last week the question of the salary to be offered to the new medical officer of health was again discussed, and after much talk it was fixed at £600 a year. It is quite understood that this figure is intended to suit a local candidate and keep trained men out of the field, but there is some hope that the Local Government Board may refuse to sanction a job such as is contemplated, or rather, fully arranged. During the last month there were 140 cases of zymotic disease notified, including 58 cases of scarlatina and 51 of typhoid and "simple continued" fever. There were 75 deaths from zymotic diseases, of which 52 were from whooping cough. The annual death-rate from all causes was 20.8. The Public Health Committee have issued special notices warning the public of the danger incurred in the consumption of shell-fish. Samples examined by Prof. Symmers at Queen's College were found to be contaminated with sewage matter. About £30,000 has now been spent in experiments with bacteria beds for the purification of sewage, but there does not seem to be much certainty as to results, for the Corporation have just sanctioned a deputation of three of their number and the City Surveyor to cross the Channel and see how the system is working in other places. Probably, however, the advent of warm weather and the holiday season has a good deal to say to this zeal in the pursuit of knowledge.

PORTADOWN AND BANBRIDGE WATER SUPPLY.—A very satisfactory piece of work was brought to a successful conclusion last week, when a supply of water from the Shimna river in the Mourne Mountains, was turned on to the towns of Portadown and Banbridge. The work has been some ten years in preparation and completion, and cost about £70,000. When first contemplated for the former town it was found to be too costly for them, but very wisely the authorities there procured the co-operation of Banbridge, with the result that both places have now an ample and excellent supply, which will no doubt be of great benefit to the health of the towns.

THE PHARMACY ACTS.—Several prosecutions under the Pharmacy Acts came on at the Londonderry Petty Sessions last week, promoted by the Pharmaceutical Society of Ireland. Two were for selling a medical prescription, the defendant not being registered as a pharmaceutical chemist, and two were for keeping open shop for the selling or retailing of medical prescriptions. The magistrates convicted, but imposed fines in two cases only, amounting to £10 and £2 costs.

BELFAST FEVER HOSPITAL.—The resident medical officers for the new fever hospital, which will probably be opened in September, were appointed last week. Mr. W. J. Leighton, M.B., was appointed senior officer at £150 a year, and Mr. E. H. M. Milligan, M.B., junior officer at £125. Both gentlemen were students of the Belfast Medical School.

MEDICAL GOLF MATCH.—The competition for the Lindsay Challenge Cup, presented by Prof. Lindsay fo competition among medical men in and around Belfast, was held this year at the Fortwilliam Park Links. The preliminary stroke competition resulted in the following eight qualifying for the match competition:—Drs. Bailey, Dempsey, Gaussen, Houston,

Kevin, MacIlwaine, H. Monypeny, and Robb. In the final round, played on the 5th inst., Dr. Thos. Houston defeated Dr. Gardner Robb by 6 up and 5 to play, thus becoming the holder of the cup for this year.

LETTERS TO THE EDITOR.

THE "CHRISTIAN SCIENCE" TRIAL.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The trial of Dr. Adcock at the Old Bailey, as you truly say, "has come to an eminently unsatisfactory conclusion," and although I am of course prohibited from commenting on this particular trial *sub judice*, I apprehend I am in order in calling attention to what appears to me an anomalous and contradictory state of the law in so frequently re-trying cases, notably, of late, some of homicide. Indeed, if I remember, there was one notorious case occurring a few years back in which the Crown abandoned any further prosecution, the jury having failed to arrive at a verdict on the second trial.

In order to make my point clear, I may be allowed to refer to an article entitled, "What Constitutes Insanity," and which you paid me the honour to insert in your journal of December 5th, 1894. In that, I attempted to differentiate in a logical or theoretical sense between sanity and insanity, selecting sound judgment or the capacity to arrive at truth as the highest standard of sanity, and any deviation therefrom as tending towards insanity. The question, therefore, resolved itself into one as to how to determine truth, and obviously as truth can only be arrived at, and not always even then, by the majority of opinion, I illustrated a trial by jury, pointing out the one dissentient juryman in any given trial would almost assuredly turn out to be a man of defective judgment. I refer to this article, because it shows the necessity for a new trial in the case where *one* obtuse juryman prevents the administration of justice, *i.e.*, a verdict.

Suppose, however, that as many as three or four jurymen dissent, the case would be entirely different; there would be something approaching a more reasonable division of opinion, and this, I think, constitutes "reasonable doubt," the benefit of which the law professes to give a prisoner. To be consistent, therefore, the law should acquit the prisoner on the first trial, unless any fresh evidence be forthcoming, because although a second jury may, haphazard or otherwise, arrive at a verdict, nevertheless, the same grounds for doubt must necessarily exist or should exist in the second as the first trial—unless, as I say, fresh evidence is produced.

Another point occurs to me with regard to "Christian Science," Generally speaking, much as I dislike so called "Christian Science," which I think could be more appropriately termed "infidel science," I cannot for the life of me understand by what legal process a qualified practitioner, under protection of his qualification, can be prevented from adopting the tenets of "Christian Science," if foolish enough to think fit, because his counsel might plead that there was no enactment to compel a doctor to administer medicine if he thought undesirable, or to prevent him from praying, if he deemed it more efficacious.

I am, Sir, yours truly,

CLEMENT H. SERS.

Brighton, July 7th, 1906.

THE BACTERIOLOGY OF THE VARTRY WATER.

SIR,—May I ask your help in stirring up public opinion as to the necessity of having a periodical bacteriological examination of the Dublin water supply. What makes the matter urgently pressing at present is that a new reservoir is about being built, and already a number of men are at work sinking pits, &c. In a few months it is expected that hundreds of workmen will be digging away at the new works, and the danger of the catchment area becoming polluted with enteric, diarrhœa and diphtheria must, in spite of every precaution, be very great. Obviously, the only possible means of detecting the pollution, before it gives rise to an epidemic, is a periodical bacteriological examination.

Unfortunately the Dublin Corporation cannot be got to see the necessity for it.

I am, Sir, yours truly,

J. C. MCWALTER, M.A., M.D, D.Ph.

THE MANUFACTURE OF PURE FOOD PRODUCTS.

SIR,—I should not venture to risk misunderstandin of my motive in writing, but I feel it a duty at this time that all experts in food production should assist by their advice in protecting the public from impurities and adulteration in all consumable articles.

Many years ago I erected in my works in this city a model room for carrying on the operations connected with the manufacture of Fruit Syrups. This room is in daily use, and has answered every purpose for which it was built. It is lofty, and ceiling, walls and floor are of cement, with a very smooth surface, all corners at sides, base or top are concaved, to permit of filtered water being daily poured from hydrant to remove dust or possible germs. The floor is slightly shelved to a centre depression to allow water to run off. The window frames and door are steel and pans of enamelled iron. No wood or porous material is used in manipulation. The Fruit Syrups are automatically filtered, mixed and passed to the Works without the slightest handling. Your representative, or any member of the medical profession, is at liberty to inspect this room at any time.

I am, Sir, yours truly,

The Old Refinery, Bristol. H. W. CARTER.

July 5, 1906.

OBITUARY.

HENRY RICHARDSON, M.D., D.D.

WE regret to note the death, on the 1st instant, of Dr. Henry Richardson, Tygwyn, Oswestry, from terrible injuries received in a cycle accident on Friday week. While cycling down Sweeney Bank, near Oswestry, he was thrown over the handle-bars of his bicycle, and alighted on his head on the road with great force. He was taken to the workhouse infirmary near the spot, and there lay in a semi-conscious state until his death. He was forty-seven years of age, and a native of Prestatyn. He held the degrees of Doctor of Divinity and Doctor of Medicine.

LITERARY NOTES.

WE have received from Messrs. Churchill a copy of the third edition of the Pharmacopœia of the Evelina Hospital for Sick Children. It contains a number of really useful formulæ and diet lists. The price of this very practical book is 1s. 6d.

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THE "University Series" of Manuals, published by Messrs. Bailliere, Tindall and Cox has been further enriched during the last few days by the addition of a "Manual of Anatomy," by Professor Buchanan, of Glasgow. The author has been so long and so distinguished in the field of anatomy that a book by him promises a successful venture.

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IN the same series two new editions of standard works have also been issued during the last few days, viz., a fifth edition of Prof. Stewart's classical "Manual of Physiology," and a second edition of Prof. Monro's "Manual of Medicine." As the first edition of the latter work appeared little more than a year ago, the call for a second so quickly would imply that it has met a requirement.

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WE are glad to welcome a new edition (the fourth) of Sir William Broadbent's work on "Heart Diseases," which has been out of print for some time. In the

production of this the author has been greatly assisted by his son, Dr. John Broadbent. Some new chapters and new illustrations have been added, and the whole work revised and brought up to accord with the most modern teaching.

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MESSRS. J. AND A. CHURCHILL have just published a work, "Preservatives in Food and Food Examination," by Dr. John C. Thresh, Lecturer on Public Health at the London Hospital Medical College and Dr. Arthur E. Porter, Assistant Medical Officer of Health and Chief Sanitary Inspector, City of Leeds. At a time when so much interest is centring around the disclosures at the slaughter-houses of Chicago, the appearance of an authoritative work bearing on the subject is opportune.

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IT is not often that a medical journal is able to bestow unqualified approval upon a pamphlet, the object of which is to make known the value of an artificial food for infants. We have, however, nothing but praise for the little essay just issued by Mellin's Food Company entitled "To Combat Infantile Mortality." It would be well if it could be mastered by every intelligent mother who needs guidance in the feeding of her baby. The food is not put forward as a panacea for all the ills that infantile flesh is heir to; and not the smallest claim is advanced for any value beyond what may be scientifically ascribed to a preparation of the kind. The prime importance of food and feeding, the superlative value of mother's milk, and the proper use of substitutes and admixtures are all clearly explained, and no mother or nurse possessing the knowledge conveyed in this pamphlet can go far wrong in the feeding of her charge.

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"The World's Anatomists" is a reprint of articles which have appeared in an American contemporary with some additions. Besides its references to the more famous of the world's anatomists, it contains several portraits. These notes when they first appeared attracted considerable attention, and in their present and more permanent form they will probably be read by a wider circle. As a contribution to medical history, this brochure must be accorded a high place. The frontispiece gives a reproduction of Rembrandt's masterpiece. A portrait of Mr. Henry Morris appears opposite page 40, while Heath and Holden also figure on the pages of this dainty volume. It is a pleasure, to note that so many of the world's anatomists are Englishmen born and bred. Many will doubtless be glad to possess this record of a department of medical science which is of immense importance in practice. The editor, Dr. Kemper, is to be congratulated in bringing before his readers such a valuable record of names. The publishers are Messrs. P. Blakiston, Son and Co., of Philadelphia.

LABORATORY NOTES,

VIRBOVEC DOUBLE CREAM.

WE have examined a tin of the "double" sterilised cream prepared in Hungary by the Virbovec Export Dairy (London Agent, R. Simpson Shaw, 17, Devonshire Square, E.C.). This double cream is especially adapted for the purpose of "whipping," but it is also a suitable substitute for fresh cream for any other purpose. A very satisfactory feature about the preparation is the freedom from the peculiar flavour which so often seriously militates against the popularity of sterilised cream—in fact, we doubt if it is possible to distinguish it from the fresh article by taste alone. On analysis we found it to be quite free from preservatives, and the tin had been in our possession several weeks; but, of course, when opened, the cream will not remain good longer than other cream in which no preservative is used. The process of sterilisation appears to be very effective, as not only is the preparation free from living micro-organisms, but the consistency and uniformity are retained to a remarkable degree. The value of a preparation possessing such valuable attributes as a means of increasing the fat in a diet is obvious. The sample gave the following figures on analysis:—Moisture, 51.27; fat, 44.89; mineral matter, 0.32; curd and sugar, 3.52. The same Hungarian export dairy put up single cream in the same form, which we found equally pure but less rich in the fat product.

NEW DRUGS.

MESSRS. PARKE, DAVIS AND CO. have sent us some of their newer preparations, and we are glad to draw the attention of our readers to the products of this trustworthy firm. Among these are "Acetozone," a germicide already well known, and Acetozone Inhalent, a solution of 1 per cent. Acetozone and 0.5 per cent. Chlorotone, in liquid paraffin, which is specially useful for treatment of the mucous membranes of the upper air passages. "Thyroidectin" is a powder prepared from the blood of dethyroidised animals, and its administration has been attended with encouraging results in the treatment of Graves' Disease. The same firm are prepared to supply tablets of scopolamine and morphine by means of which anæsthesia can be induced with great ease and without unpleasant after-effects. Their Throat Mentholated Tablet, without cocaine, also, is a promising preparation.

WE have received from Messrs. Burgoyne, Burbidge, and Co. a sample of their emulsion of Cod Liver Oil, with hypophosphites of lime, potash, and soda. The emulsion is beautifully prepared, and in appearance and consistence it resembles a rich cream. It is claimed that this preparation is not followed by nausea and eructations, such as commonly follow the administration of cod liver oil, and that the emulsion retains its characters under all conditions. The makers deserve credit for producing this elegant preparation of a useful but distasteful drug.

"SAJODIN" is one of the Bayer Company's new products. It is reputed to be an efficient substitute for potassium iodide, and at the same time to be incapable of inducing iodism. If these claims be borne out in practice, Sajodin should find an unusually large field of usefulness before it. Neatly made up packets containing 15 grains are supplied.

North-East London Clinical Society.

THE annual general meeting of this society was held at the Tottenham Hospital on Thursday, July 5th, 1906. The following officers were elected for the ensuing year: President, Dr. A. E. Giles; Hon. Treasurer, Mr. H. W. Carson; hon. secretaries, Dr. G. P. Chappel and Mr. C. E. Hutt. The meeting then resolved itself into a garden party, held in the beautiful grounds of the hospital, by kind permission of the Governors. The new wards and operating theatre were open to the inspection of visitors.

Cholera in the Philippines.

THE American War Department has received advices from Manila stating that there were 116 cases of cholera with 99 deaths in Manila for the week ending July 4, and that during the last twenty-four hours there had been in the provinces twelve cases and five deaths, and in Manila 29 cases and 23 deaths.—Reuter.

Milk and Scarlet Fever.

A SUDDEN increase in scarlet fever cases in Tottenham and Edmonton has been inquired into by the county medical officer, who reports that 16 cases were traced to customers of one milk vendor, the milk having come from a London contractor. About 59 per cent. of the whole of the cases investigated in one week were among persons whose milk was supplied by this contractor.

MEDICAL NEWS IN BRIEF.

Royal College of Surgeons of England—Council Election.

The annual meeting of Fellows took place on Thursday last, for the purpose of electing three Fellows on the Council of the College. After the counting of votes, the president (Mr. John Tweedy) declared the result of the poll as follows:—Mr. George Arthur Wright of Manchester, 462 votes, and 46 plumpers; Mr. Henry Morris, of Middlesex Hospital, 386 votes and 21 plumpers; Mr. Francis Richardson Cross, 340 votes and 10 plumpers; Mr. Charters James Symonds, 316 votes and 51 plumpers; and Mr. William Bruce Clarke, 305 votes and 48 plumpers. Mr. Morris and Mr. Cross were therefore re-elected, and Mr. Wright was elected members of the Council; 750 Fellows voted by post, and only nine in person. Messrs. Willmott Evans and Henry J. Price (Malden) acted as scrutineers. In the evening a Fellows' dinner was held in the College, at which about eighty were present. After the toasts of "The King" and "The Royal Family" had been duly honoured, the president proposed the toast of the evening, "The Fellowship of the Royal College of Surgeons of England." This was responded to by Mr. W. D. Spanton, of Hanley, and Sir Edgcumbe Venning, Mr. Clinton Dent, and Mr. G. H. Makins, C.B., were the hon. secretaries of the dinner, and at the close a copy of the recently-prepared "Historical Summary of the History of the College" was presented to each Fellow present.

Apothecaries' Hall of Ireland.

THE Worshipful Company of Apothecaries met last week to confer the honorary degree of L.A.H. on Sir Christopher Nixon and Professor Denis Coffey. The Deputy-Governor (Dr. Stritch) said:—"It is my privilege to present to you an illustrious member of the medical profession, Sir Christopher John Nixon. His path through life has been marked by such singular and well deserved success that, whilst we admire his great intellectual abilities, we must marvel at the strength of purpose which enabled him to surmount ordinary difficulties and reach that pinnacle of fame he now enjoys. He is Senior Physician in the Mater Misericordiæ Hospital, where his cliniques have always been of surpassing success and popularity. Her Majesty, our late beloved and ever-regretted Queen, was pleased to create him a Knight Bachelor, and to-dayall English-speaking people read of the distinction conferred upon him by our gracious Sovereign King Edward VII." Dr. Stritch then said:—"He whom it is now my privilege to present to you is a distinguished scientist of universal reputation, Dr. Denis Joseph Coffey, M.A., M.B., B.Ch. and B.A.O., Fellow of the Royal University of Ireland, Professor and Examiner in Physiology of the Royal University of Ireland, Lecturer on Physiology and Biology, St. Patrick's College, Maynooth (applause). A University which is proverbially jealous of her reputation, which conscientiously labours incessantly to discharge her immense responsibilities to mankind by the adequate instruction of her students—this University has, as already stated, testified her appreciation of Dr. Coffey's attainments by appointing him to the exalted position of one of her Professors." Dr. Montgomery (as the senior member of the Apothecaries' Hall) proposed the following resolution:—"That the Governor and Court of the Apothecaries' Hall of Ireland tender to the Medical Faculty of the Catholic University School of Medicine hearty congratulations on the attainment of their golden jubilee, and they are greatly pleased, in the interests of science and the common weal, to have observed the ever increasing standard of efficiency which has been maintained during the fifty years that have elapsed since the school passed from under the control of this Hall."—Dr. Evans seconded the resolution, which was carried unanimously. The governor then admitted Sir Christopher Nixon and Professor Coffey, who replied.

Guy's Hospital Prize Distribution.

THE annual distribution of prizes at Guy's Hospital Medical School took place on the 4th inst., the chief awards being: Open scholarships in arts—H. L. Hopkins, Owen's School, £100; A. H. Todd, Sherborne School, £50. Open scholarships in science—M. A. E. Duvivier, Guy's, £150; T. D. Macgregor Stout, Guy's, and A. N. Cox, Derby School, equal, £30 each. Scholarship for University students—C. G. Douglas, B.A., Magdalen College, Oxford, £50. Open scholarships in dental mechanics (October, 1905)—E. J. Archer and W. E. Guilding, equal, £10 each; (May, 1906) D. B. Tasker, £20. Junior proficiency prizes—H. B. Kent, £20; C. A. Wood, £15; J. J. Darke, £10. Michael Harris prize for anatomy—H. B. Kent, £10. Wooldridge memorial prize for physiology—J. L. Atkinson, £10. Hilton prize for dissections—H. B. Kent and W. E. Williams, equal, £2 10s. each. Arthur Durham prizes for dissection (first year's students)—R. P. Ballard, £5; (senior students) H. B. Kent, £15. Dental prizes (first year's students)—H. C. Visick, £10. Treasurer's gold medal for clinical medicine—P. P. Laidlow. Treasurer's gold medal for clinical surgery—G. Cockcroft. From the annual report, read by the Dean, it as shown that, notwithstanding the generally diminished entry at the metropolitan schools of medicine, the number of students who had joined Guy's during the past 12 months gave a distinct increase over that of the preceding year. The most pressing need of the school at the present time was a sum of £10,000 for the endowment of a chair in pathology. This subject, which was the key to all advancement in the science and art of medicine, was growing so much in extent and importance that the school had decided that at the earliest opportunity a department of pathology must be instituted, with a separate staff of lecturers and demonstrators. This important step could not be taken without further monetary assistance, but it was hoped that such endowment might be forthcoming, and a department instituted which would enable the subject to be taught in a manner worthy of such a great school of medicine as that of Guy's Hospital.

The Money Value of Patent Medicines.

AN outcry is being raised in the scientific journals of the United States at the growth of the drug habit which is even more apparent there than in England. The *Morning Post* asserts that nearly £20,000,000 a year is spent in the United States on patent medicines, which may roughly be divided into "soothing syrups," "cough syrups," or "pectorals," "catarrh cures," and "headache cures." The "soothing syrups" nearly all contain opium, and are specially vicious when given to children; the "cough syrups" frequently contain the same drug; the "headache powders," which do not contain opium are almost without exception preparations of acetanilid, a substance derived from coal tar, which, although not so dangerous as morphine, produces an insidious weakening of the heart when used repeatedly. The "catarrh cures" contain cocaine; the "pick-me-ups" some form of alcohol. Our contemporary agrees with us that on both sides of the Atlantic it should be made compulsory for all proprietors of patent medicines containing any of these constituents to state on the label the amount of poisonous ingredients present.

Health Congress in Dublin—Consumption in Ireland.

THE annual Congress of the Royal Institute of Public Health opened at Cork on the 27th inst. Delegates assembled at the municipal buildings, where they were received by the High Sheriff, in the unavoidable absence of the Lord Mayor. A procession was formed at the municipal buildings, and the delegates, who comprised forty mayors from different parts of the kingdom, drove in open carriages to Queen's College, where the inaugural meeting was held. The High Sheriff having welcomed the delegates, Professor Smith, president of the Royal Institute, addressed the Congress. He said that consumption was a matter of grave moment in Ireland. In England the mortality from that disease had been gradually diminishing, while in Ireland it was increasing. When they came to Cork they had a far more lamentable fact to face, namely, that of all the cities in Ireland Cork headed the list in its death-rate from phthisis. It was a circumstance of the greatest gravity, not only for the City of Cork, but for the corporation and the citizens. It behoved somebody to look into the matter to see what could be done to reduce the enormous mortality from what they knew was a preventable disease. Professor Smith afterwards invested Prof. Windle with the insignia of office as president of the Congress.

Prof. Windle, in his inaugural address, referred to the excessive death rate from consumption. He said side by side with the advancing mortality from tubercle there was an alarming increase in the number of insane. Of every ten thousand persons in Ireland 52·6 were registered as lunatics or idiots, the figure in England and Wales being 34.71 per ten thousand.

Measles and Phthisis Notification.

THE Public Health Committee of the Edinburgh Town Council at its meeting last week, had before it a motion by Judge Macpherson as to the desirability of notifying the first case of measles occurring in a family. It turned out the Committee were equally divided in their opinion, a motion being made that no notification be made. On a division six voted for Judge Macpherson's proposal and six against. Judge Macpherson who presided in the absence of the convener, gave his casting vote in favour of his proposal, and the committee decided to recommend accordingly. A motion by Councillor Robertson as to whether the time has not now arrived for the compulsory notification of phthisis was sent to a sub-committee for report.

Laudanum in Quantities.

WILLIAM HENRY WHITTY, thirty-eight, tailor's manager, was last week, charged at West London with attempting suicide. The police produced a good-sized bottle three-parts full of laudanum.—Mr. Kennedy (the magistrate): Do you mean to say a chemist sold all this laudanum to you at once?—Defendant: Yes, sir. I had had acute neuralgia, and I took some whisky. Then a friend recommended me to try laudanum, and I bought that bottle. I had no intention of killing myself.—Mr. Kennedy: Didn't the chemist ask you to sign a book?—Defendant: No, sir. I drank some in the shop doorway.—Mr. Kennedy: The police had better make some inquiries at that shop. You can be discharged since it appears you took the laudanum to allay pain.

The Heidelberg Conference on Cancer.

THE International Conference for the prevention of cancer, is announced to meet at Heidelberg at the end of September. On the 26th of that month, the delegates will assemble at Heidelberg, and on the next day will be addressed by the president, Professor von Leyden. In the afternoon a visit will be paid to the new local Cancer Institute. The following day members will adjourn to Frankfurt, where they will inspect the institute for experimental therapeutics, and also the scientific collection. On the 27th, there will be lectures and demonstrations by members of the Berlin cancer division of the first medical infirmary.

St. Mary's Hospital Medical School—South African War Medal.

THE annual distribution of prizes to the successful students will be made by the Director-General of the Army Medical Service on Monday next, July 16th, at 4 p.m. After the presentation of prizes in the Library the Memorial Bronze erected in the entrance hall of the Clarence Wing, to the memory of members of the Hospital and Medical School who lost their lives during the South African War, will be unveiled by the Director-General of the Army Medical Service.

The Annual Medical Tour in Germany.

DR. OLIVEN, Secretary-General of the German Medical Tour, asks us to announce that the tour this year will start on September 2nd, at Heidelberg, finishing on September 15th at Stuttgart. The following watering-places will be visited:—Wildbad, Fernach, Freudenstadt, Rippoldsar, Badenwerber, Tadtmars, St. Blasia, Schaffhausen, Konstang, Triberg and Baden-Baden. The price of the whole tour (wine excluded) is £11 5s. Programme, etc., to be had from Dr. Oliven, Berlin N.W. Linsenplatz, 2–4.

Society of Apothecaries of London.

THE following candidates, having passed the necessary examinations, have received the L.S.A. Diploma of the Society, entitling them to practise medicine, surgery and midwifery:—A. J. Ambrose, D. L. E. Bolton, A. W. S. De Vine, R. C. T. Evans and P. Moxey.

PASS LIST.

College of Physicians and Surgeons—Examination Results.

THE following gentlemen passed the recent second examination in anatomy and physiology:—
Edward Bruce Allnutt, St. Bartholomew's Hospital; Manekjee Dhanjishaw Anklesaria, L.M. and S. Bombay; Tom Chamney Russell Archer, St. Thomas's Hospital; John Lee Atkinson, Guy's Hospital; Charles William Tresidder Baldwin, Charing Cross Hospital; Jehangir Cowasjee Balsara, L.M. and S., L.R.C.P., and S. Edinburgh, of Bombay; Ernest Cuthbert Barnett, New Zealand; Donald Maxwell Cox, Charing Cross Hospital; Ernest Edgar Davies, University College, Bristol; Archibald Wallace Duncan, St. Mary's Hospital; Evan Richard Evans, St. Bartholomew's Hospital; Walter Andrew Fernando, Ceylon and King's College; Philip Charles Field, University College, Bristol; Richard Sydney Graham, St. Mary's Hospital; Guy Fleetwood Haycraft, Guy's Hospital; Martin Hallam, Sheffield University; James Frank Hoare, University College Hospital; Maurice Lionel Corrie Irvine, St. Thomas's Hospital:; John Lawrence Johnston, Guy's Hospital; Walter Foulkes Jones, B.A.Cantab., Cambridge University, St. George's and King's College Hospitals; Abdus Sattar Khan, L.M. and S., Calcutta; Latafat Husain Khan, Bombay and St. Bartholomew's Hospital; Henry Goff Kilner, Middlesex Hospital; Framroze Kolaporewalla, Bombay, and Guy's Hospital; Russell Hardy Sidney Marshall, St. Mary's Hospital; Charles Anderson Meaden, St. Bartholomew's Hospital; John Cecil Wilson Methven, London Hospital; James Knowles Milligan, St. Thomas's Hospital; Frank Cyril Morgan, University College, Bristol; Albert Edgar Nicholls, University College, Cardiff; Frederick Cecil Nichols, Bristol; Richard Goodhart Oram, Guy's Hospital; William Robert Parkinson, Otago and St. Thomas's Hospital; Guy Harcourt Peall, Guy's Hospital; Charles Arnold Pemberton, Otago and Middlesex Hospital; Arthur Thomas Pitts, L.D.S., Middlesex Hospital; Quintin Hume Richardson, Guy's Hospital; Archer Ryland, St. Bartholomew's Hospital; Frank Stuart Tamplin, St. George's and King's College Hospitals; Jocelyn Langton Waller, St. Mary's Hospital; Thomas Newlands Watt, Otago; Walter Weir, St. Thomas's Hospital; Charles Whitaker, St. Bartholomew's Hospital; Cyril Underwood Whitney, Westminster Hospital; and Arthur John Ormsby Wigmore, University College, Bristol.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS.

ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT LITERATURE OF PHYSIOLOGY AND PATHOLOGY.

Regeneration and Recurrence of Lymph Glands and Vessels.—Meyer contributes to the June number of the *Johns Hopkins Hospital Bulletin* a most interesting and valuable paper on the above subject. As regards regeneration of lymphatic tissue after destruction or removal, he points out that great difficulty arises in distinguishing inflammatory re-action from actual tissue renewal, and that, furthermore, the existence of lymphadenoid nodules scattered diffusely through the adipose tissue of such regions as the axilla introduces an additional difficulty, and one which is readily surmountable when it is remembered that lymph glands may themselves undergo a fatty metamorphosis. Up to this very conflicting results have been recorded with reference to regeneration of partially excised glands, partly perhaps depending on the age of the animals experimented on and partly on variations in the completeness of subsequent examinations. Meyer's own experiments, which were, however, complicated by suppuration some days after operation, were negative as far as regeneration was concerned, and are in agreement with the results obtained by Heuter. As regards recurrences from fat of excised glands, Meyer's experiments also were negative. Most of his experiments were upon the glands of the popliteal region, and the interval between operation and the subsequent examination varied from 25 to 161 days. In none of them was the slightest evidence in favour of recurrence obtained, and since the only previous experimental evidence in its favour was the result of one operation by Bayer, it may be concluded that recurrence very seldom or never takes place. Eight operations were carried out in the large lymphatic trunks of the lower limb in dogs. The vessels were first injected with pigment, introduced through the pad of the foot, in order to make them visible and then portions of them were excised. After intervals varying from 14 to 91 days the wounds were opened up, and in no single case was the smallest evidence of regeneration found. Instead, the cut ends of the lymph glands were found embedded in scar tissue, and no trace of vessels could be found in the intervening space. A similar result was obtained in one operation on the mesenteric lymphatics.

M.

Paroxysmal Cyanosis with Polycythæmia.—Parkes Weber reports a case (*Edinburgh Medical Journal*, June, 1906, p. 525) of the above described condition, in which congenital cardiac disease was present, as evidenced by the existence of a loud systolic murmur audible all over the pericardium. The red cells numbered over 7,000,000 per c.mm., and the white cells 17,000, while the hæmoglobin reached 130 per cent. as compared with the normal. The attacks of cyanosis were intermittent, and chiefly dependent on mental and physical exertion. No sign of unusual hypertrophy of the heart or of failing compensation was present. They believe the condition to be one of patent interventricular septum, and regard the case as in favour of the view that the cyanosis of morbus coeruleus is due to mixture of venous and arterial blood, inasmuch as no signs of œdema or of enlargement of the liver were present indicative of cardiac inadequacy, despite the fact that the patient was past the age of puberty.

M.

Viscosity of the Blood.—Bence has investigated, with the aid of the apparatus devised by Hirsch and Beck, the viscosity of the blood in cyanotic conditions (*Zeitschrift f. Klin. Med.* Bd. 58, p. 205) and finds it to be increased from 25 to 52 per cent. above the normal. Owing to the increase of viscosity an additional obstruction to the circulation is introduced, and this is sometimes sufficient to give rise to cardiac dilatation. Respiration of oxygen gas can diminish the viscosity and even bring it down to normal. Further investigations, however, proved that the presence of excess of carbon dioxide gas played a part in increasing the viscosity, as well as the diminution of oxygen. In seven cases of kidney disease also the blood was found to be more viscous than normal, and to this Bence attributes the left ventricle hypertrophy of chronic Bright's disease. Alteration in diet [illegible] to have any influence at all on the viscosity. As a direct result of the increased viscosity water must pass from the blood plasma into the corpuscles, which necessarily renders the corpuscles larger and [illegible] increases the thickness of the plasma. Both of these conditions continue to increase the friction as the blood traverses the capillaries.

M.

The Fate of Erythrocytes introduced into the Circulation of Animals.—Levaditi has made investigations (*Travail du laboratoire de M. Metchnikoff a l'institut Pasteur*) upon the fate of red cells introduced (*a*) into animals immunised against them, and (*b*) into animals not so immunised. When one injects from one to two cc.m. of an emulsion of the red cells of a pigeon into a rabbit through the jugular vein it is noticed that the immunised rabbits shortly after the injection suffer severely from dyspnœa and general debility, while non-immunised animals do not show any disturbances. From this observation the author concludes that an important difference exists between anti-microbial and cell immunising substances. The former apparently protect the body against the poisons of broken-up bacilli, while the latter lower the general body resistance to cellular poisons. Levaditi believes that in the case of the immunised animals the erythrocytes are broken up so rapidly as to set free sufficient material to cause coagulation of the blood, and that this coagulation taking place in the pulmonary capillaries leads to asphyxia. In non-immunised animals hæmolysins are only present in small amounts and the circulation is therefore not flooded with coagulation producing substances.

M.

Pathology of Puerperal Eclampsia.—Eliza Dunbar (*Bristol Medico-Chirurgical Journal*, June, 1906) puts forward a "new theory" of puerperal eclampsia. This is to the effect that eclampsia is the result of the collection of semi-solid material in the tissues, due to inactivity of the thyroid gland. In other words, puerperal eclampsia is myxœdema occurring in relation to pregnancy or the puerperium. In support of this theory, Dr. Dunbar adduces an alleged cure of eclampsia by the administration of thyroid extract. She believes in some close relations between the functions of the thyroid gland and of the genital organs, and apparently she thinks that the presence of pregnancy makes an additional demand on the activity of the thyroid, which results in myxœdema. The theory is not new, but is sufficiently bizarre to demand much more argument in its favour than Dr. Dunbar either adduces or appears to think necessary before it merits serious consideration.

R.

Tuberculosis of the Thoracic Duct.—Longcope (*Bulletin of the Ayer Clinical Laboratory of the Pennsylvania Hospital*, No. 3, June, 1906) reviews the literature of tuberculosis of the thoracic duct, and gives details of 30 cases of generalised tuberculosis which were examined either by himself or by MacCallum, of Johns Hopkins. Of the 30 cases, 19 were typical instances of generalised acute miliary tuberculosis.

Where histories could be obtained, the course of the disease was rapid, lasting from two to twelve weeks. Of these 19 cases in 15 the thoracic duct was affected. Of 8 cases of chronic or subacute tuberculosis, the thoracic duct was affected in only two, while in three cases of a chronic type the thoracic duct was normal. In all cases in which the thoracic duct was extensively affected, the lymph nodes of the mesentery, retro-peritoneum, and posterior mediastinum were the seat of a chronic tuberculosis. This intimate association between the condition of the ducts and that of the lymph nodes leads Longcope to believe that the infection travels directly from the latter to the former by means of the lymphatics. He thinks, further, that the thoracic duct is of great importance as a channel for the spread of tubercle bacilli through the body from the various groups of lymph nodes. He concludes that tuberculosis of the thoracic duct is of great frequency in cases of acute generalised tuberculosis. The lesions in the duct, from which tubercle bacilli are swept in great numbers through the lymph to the general circulation forms the starting point of the generalised acute process. R.

Cerebro-Spinal Meningitis.—Robinson (*Bulletin of the Ayer Clinical Laboratory of the Pennsylvania Hospital*, June, 1906), publishes an account of the bacteriological findings in fifteen cases of epidemic cerebro-spinal meningitis. His experience is in agreement with received opinion as to the constancy of the occurrence of the diplococcus of Weichselbaum in the spinal fluid. He only met with this organism, however, in the circulating blood in two out of four cases investigated, and he is of opinion that it is only an occasional invader of the blood. Its presence, however, may persist for several days, and is not merely agonal. He had the opportunity of examining two cases of purulent conjunctivitis occurring in the course of the disease, and from the pus of one of these the diplococcus was isolated. His experience is that the broncho-pneumonia, which not infrequently terminates the disease, is due to pyogenic organisms, and not to the diplococcus. R.

The Clinical Examination of the Cerebro-Spinal Fluid.—Purves Stewart (*Edinburgh Medical Journal*, May, 1906) discusses the clinical lessons to be derived from an examination of the cerebro-spinal fluid. (1) *Physical Characters:* Whereas the normal fluid is clear and colourless, in cases of meningitis it may be cloudy or even purulent. In severe jaundice, it may be yellow, but clear, whereas in cerebral or spinal hæmorrhage, it may be blood-stained. This point is of much importance in the diagnosis between hæmorrhage and thrombosis in cases of sudden hemiplegia. (2) *Chemical characters:* Excess of albumin occurs in acute meningitis. In general paralytics Gullain and Paraut have discovered with great constancy a precipitate which persists after the coagulation and removal of the serum-globulin and albumose of ordinary cerebro-spinal fluid. (3) *Bacteriological characters* serve to distinguish the different forms of meningitis due to different causative organisms. The failure to find any organisms in a case of undoubted meningitis is suggestive of tubercle. (4) *Microscopic characters:* The nature of the cells present is of much importance. Whereas the normal fluid contains a few endothelial cells and a few lymphocytes, in all cases of acute meningitis, polymorphonuclear leucocytes are present in considerable numbers. In more chronic affections of the meninges, on the other hand, and also in certain chronic degenerations, such as tabes dorsalis and general paralysis, lymphocytes are present in large numbers. Microscopic examination may also reveal the presence of tumour cells, or of organisms. R.

Sign of Death.—Ott (*Journal de Medicine et de Chirurg. Prat.*, February 26th, 1906) describes a sign of death easy of application. A taper or match is applied to the palmar surface of the forearm, and the part touched by the flame carefully watched. If the subject be dead, the epidermis rises like a bubble and bursts, no exudation being observed. On the other hand, if the subject be alive and any circulation present, a distinct blister is formed. R.

New Methods of Clinical Pathology.—Walker Hall (*Bristol Medico-Chirurgical Journal*, June, 1906) describes certain methods of clinical pathology recently introduced which he thinks likely to be of interest to the physician. (1) *Gastric contents:* Sahli's method for determining the presence of free hydrochloric acid in the stomach is commended. Instead of the so-called "test meal" Sahli allows a full meal, which is followed immediately by the administration of a pill of methylene blue enclosed in a well-made catgut capsule. The latter can only be dissolved by free HCl, and the appearance of blue pigment in the urine determines the presence of HCl in the stomach. (2) *Fæces:* When examining fæces for the eggs of intestinal parasites, the fæces should be made liquid by the addition of 10 per cent. formal solution. Smears should then be made on slides, fixed with 1 per cent. osmic acid vapour for two minutes, and mounted in glycerin. (3) *Urine:* Krokiewicz proposes the following test to demonstrate the presence of bile:—Add equal amounts of a watery solution of sodium nitrite and of sulphanilic acid to a few drops of urine, and then pour in one or two drops of concentrated hydrochloric acid. With normal urine a ruby red colour appears, whereas if bile be present the colour is amethyst violet. To demonstrate aceto-acetic acid in the urine, Riegler's test is recommended:—To 1 cc. of normal urine add 2 cc. of 10 per cent. iodic acid solution, and 3 cc. of chloroform. Shake. The chloroform turns violet. Add 10 cc. of the urine to be examined. If aceto-acetic acid be present, the chloroform will be discoloured. Walker Hall gives many other methods; we have selected those most likely to be of use to physicians. R.

Channels of Infection with Tuberculosis.—Calmette and Guérin (*Annales de l'Institut Pasteur*, May 25, 1906) give an account of their more recent experiments bearing on the modes of infection with tuberculosis. It will be remembered that in a previous number they related that adult goats, when fed with tubercle bacilli, by the help of an œsophageal tube, easily became infected, but that the disease attacked not the mesenteric glands, but the lungs. This conclusion was in direct opposition to the view of Von Behring, that tuberculosis of the adult is the result of an intestinal infection received when young. The authors have now performed a similar set of experiments in the case of adult cows, with similar results. The effect of these researches may be summed up as follows:—(1) Animals easily become infected with tuberculosis by the path of the intestines, not only in youth, but in adult life, without the passage of the bacilli through the walls of the intestine leaving very visible lesion; (2) in young animals, the bacilli are usually stopped by the mesenteric glands. Sometimes the infection passes no further, but after a longer or shorter duration, becomes cured. Sometimes, on the other hand, typical lesions appear, followed by a general infection travelling along the lymphatic vessels; (3) in adult animals, the defensive activity of the mesenteric glands being less, the bacilli pass more rapidly into the general circulation; (4) the pulmonary tuberculosis, commonly described as "primary," is most often of intestinal origin; (5) of all modes of tubercular infection, infection by the digestive tube is the most efficacious. R.

NOTE.—*A Summary will appear each week in the following sequence:*—(1) "*Recent Medical Literature.*" (2) "*Recent Surgical Literature.*" (3) "*Recent Gynæcological and Obstetrical Literature.*" (4) "*The Recent Literature of Physiology and Pathology.*"

NOTICES TO CORRESPONDENTS, &c.

☞ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, to 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 proofs.

CONTRIBUTORS are kindly requested to send their communications if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

R. G. BAILEY.—A reference to the recently-issued report of the Army Medical Department will show that about one in five applicants were rejected on the score of defective teeth. There is room for doubt whether this exclusion does not represent a counsel of perfection. There are bad teeth and bad teeth, and the effect on general bodily fitness to a great extent depends on contributory factors, such as food, fresh air, exercise, and, above all, the period of life.

FOOD CONTAMINATION.

A MANCHESTER correspondent has drawn our attention to an article that appeared recently in a local newspaper. The superiority of peas over butcher meat is therein ably advocated, both on the score of cheapness and of absence of contamination. We can only assure our correspondent that the shelling of peas for market purposes is often conducted under revolting conditions of filthiness on the part of the waifs and strays who handle the pods.

MR. CURWEN.—The only cities of the United States of which we have official statistics as to population are:—New York with 4,152,860, Chicago 2,049,185, Philadelphia 1,469,126, Boston 617,950. St. Louis probably comes next to these in point of numbers, and San Francisco closely following before the recent earthquake.

A. B. S. (Burnley).—A new edition of the work has been recently announced. See reference thereto in our "Literary Notes" column.

DR. H. S. T. will receive a private note as soon as the necessary information is obtained. We think, however, it will be in the negative.

THE AMMANFORD COLLIERY POST.

WITH reference to our caution as to the Ammanford Colliery medical appointment we gave from the *South Wales Daily Post* the post was declined by Dr. Martin, of Treorky, but was later accepted by Dr. Scott, of Cwmtwrch.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JULY 11th.

DERMATOLOGICAL SOCIETY OF LONDON (11 Chandos Street, Cavendish Square, W.).—5.15 p.m. Meeting.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. T. P. Legg: Clinique. (Surgical). 5.15 p.m. Lecture:—Dr. C. O. Hawthorne: Pulse Tracings and their Clinical Significance.

LONDON SCHOOL OF CLINICAL MEDICINE (Dreadnought Hospital, Greenwich).—2.30 p.m. Operations. Dr. F. Taylor: Medicine. 3.15 p.m. Mr. M. Robson: Surgery. 4 p.m. Mr. Cargill: Ophthalmology. Out-patient Demonstrations:—10 a.m. Surgical and Medical. 11 a.m. Eye.

THURSDAY, JULY 12th.

BRITISH GYNÆCOLOGICAL SOCIETY (20 Hanover Square, W.).—8 p.m. Specimens will be shown by Dr. Macnaughton Jones, Dr. J. Aarons, and Dr. C. Maunsell. Papers:—Dr. J. Oliver: A Study of Hydatidiform Mole, with Records of Three Typical Cases. Dr. Macnaughton-Jones:—Remarks on Closure of Small Recto-vaginal Fistula involving the Sphincter.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m. Lecture:—Mr. H. S. Clogg: Peritonitis in Children.

LONDON SCHOOL OF CLINICAL MEDICINE (Dreadnought Hospital, Greenwich).—2.30 p.m. Operations. Dr. G. Rankin: Medicine. 3.15 p.m. Sir W. Bennett: Surgery. 4 p.m. Mr. M. Davidson: Radiography. Out-patient Demonstrations:—10 a.m. Surgical and Medical. 12 noon. Ear and Throat.

FRIDAY, JULY 13th.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street, Cavendish Square, W.).—8 p.m. Card Specimens. 8.30 p.m. Papers: Mr. W. T. H. Spicer: Intraocular Infectives. Mr. A. R. Bralley: Congenital Distichiasis. Mr. C. H. Usher (Aberdeen): A Note on the Chorold at the Macular Region. Annual General Meeting. Election of Officers for 1906-07.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. E. Clarke. Clinique. (Eye).

LONDON SCHOOL OF CLINICAL MEDICINE (Dreadnought Hospital, Greenwich).—2.30 p.m. Operations. Dr. R. Bradford: Medicine. 3.15 p.m. Mr. McGavin: Surgery. Out-patient Demonstrations:—10 a.m. Surgical and Medical. 12 noon. Skin.

SATURDAY, JULY 14th.

LONDON SCHOOL OF CLINICAL MEDICINE (Dreadnought Hospital, Greenwich).—2.30 p.m. Operations. Out-patient Demonstrations:—10 a.m. Surgical and Medical. 11 a.m. Eye.

MONDAY, JULY 16th.

ST. MARY'S HOSPITAL MEDICAL SCHOOL.—Presentation of Prizes and Unveiling of S. Africa War Memorial by Surgeon-General Sir A. Keogh, K.C.B., at 4 p.m.

Vacancies.

Egyptian Government.—Ministry of Education.—Professor of Midwifery and Gynæcology. Salary £400 a year, with private practice. Applications to the Director, School of Medicine, Cairo, Egypt.

Egyptian Government.—Ministry of Education.—Medical Tutor and Registrar to Kasr-El-Ainy Hospital. Salary £400 a year. Applications to the Director, School of Medicine, Cairo, Egypt.

Royal Dental Hospital of London, Mechanical Pupils' Department.—Demonstrator. Salary £120 per annum. Applications to the Dean, 32 Leicester Square, W.C.

Royal City of Dublin Hospital.—Anæsthetist, Pathologist, and Dentist. Immediate application to Mr. G. Jameson, Hon. Sec Medical Board. (See advt.)

Victoria Hospital, Burnley.—Resident Medical Officer. Salary £100 per annum, with residence, board, and washing. Applications to F. A. Hargreaves, Hon. Sec., 7 Grimshaw Street, Burnley.

The Hartlepools Hospital. House Surgeon. Salary £100 per annum, with board, washing, and lodging in the Institution. Applications to Robert Edger, Secretary, 15, Town Wall, Hartlepool.

University of Manchester.—Junior Demonstrator in Physiology.—Salary £100 per annum. Applications to the Registrar.

Wandsworth Union Infirmary, St. John's Hill, near Clapham Junction.—Junior Assistant Medical Officer. Salary £100 per annum, with board, lodging, and washing. Applications to the Medical Superintendent.

Required for Railway in South America.—Assistant Medical Officer. Salary £350 per annum. Address, A. R., care of Messrs. Charles Barker and Sons, 8 Birchin Lane, E.C.

Bradford Royal Infirmary.—Dispensary Surgeon. Salary £100 per annum, with board and residence. Applications to Edmund Forster, Secretary.

Littlemore Pauper Lunatic Asylum, near Oxford.—Second Assistant Medical Officer. Salary £150 per annum, with furnished rooms and board. Applications to Thomas M. Davenport, Clerk of the Visiting Committee, County Hall, Oxford.

Manchester.—Chorlton-upon-Medlock Dispensary.—Resident House Surgeon. Salary £120 per annum, with furnished rooms and attendance. Applications to the Hon. Secretary.

Appointments.

GRAY, A. M. H., M.D., B.S.Lond., Resident Medical Officer at University College Hospital.

ODGERS, N. B., M.B., M.Ch.Oxon., F.R.C.S.Eng., Assistant Surgeon to the General Hospital, Northampton.

RAMSAY, A., M.B., M.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Leadhills and Wanlockhead District of the counties of Lanark and Dumfries.

RING, C. A. E., L.R.C.P. and S.Edin., L.F.P.S.Glasg., District Medical Officer by the Okehampton (Devon) Board of Guardians; also Certifying Surgeon under the Factory and Workshop Act for the Hatherleigh District of the county of Devon.

ROSE, FRANK A., M.B., B.C.Cantab., F.R.C.S.Eng., Surgeon to the Ear and Throat Department with Charge of Out-patients at the Great Northern Central Hospital.

SMITH, S. MAYNARD, M.B., B.S.Lond., F.R.C.S.Eng., Surgeon in Charge of Out-patients at St. Mary's Hospital.

SUTHERLAND, J. R., M.B., Ch.B.Glasg., Junior House Surgeon at the Blackburn and East Lancashire Infirmary.

WILSON, A. GARRICK, M.B., M.C.Cantab., F.R.C.S.Eng., Surgeon to the Sheffield Children's Hospital.

Births.

BARNETT.—On July 6th, at 23 Hillgrove Road, South Hampstead, the wife of Lawrence Barnett, M.D.Lond., of a daughter.

CUNNINGHAM.—On July 7th, at Firenze, Malone Park, Belfast, the wife of H. H. B. Cunningham, M.D., F.R.C.S.I., of a daughter.

Marriages.

BODINGTON—RIVIERE.—On July 5th, at St. Paul's Church, South Hampstead, Arthur Eaton Bodington, M.A., M.D., of Winchester, son of the late G. F. Bodington, M.D., F.R.C.S., to Theodora, younger daughter of Briton Riviere, R.A., of Flaxley, 82 Finchley Road.

DIXSON—ROBERTSON.—On July 5th, at St. Paul's Church, Brentford, Charles Frederick Lyne Dixson, M.D., M.R.C.S., to Jessie May Robertson, eldest daughter of Mrs. Newcombe, of Clovelly, Boston Road, Brentford.

DRAPER—DIXON.—On July 7th, at St. Matthew's Church, Upper Clapton, John R. Draper, B.A., M.B., B.C. (Cantab.), youngest son of the late Thomas Draper, of Bradley Hall, Eccleston, Lancashire, to Nellie, eldest daughter of Robt. Dixon, Alconbury Road, Upper Clapton.

GRIFFITH—GOODE.—On July 5th, at the Parish Church, Hampton, Richard, elder son of Samuel Griffith, M.D., J.P., Portmadoc, North Wales, to Mary Greayer (Cissy), elder daughter of John Charles Goode, of Castle House, Hampton, Middlesex.

HAMMOND-SMITH—PARAMORE.—On July 4th, at Christ Church, Woburn Square, London, Arthur Hammond Smith, L.D.S., of Anerley, King's Road, Reading, to Florence Maud, the younger daughter of Richard Paramore, M.D., of 2 Gordon Square, London.

Deaths.

HILL.—On July 6th, at St. Keverne, Lymington, Hants, William Robinson Hill, M.D., J.P., aged 70 years.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIII. WEDNESDAY, JULY 18, 1906. No. 3.

NOTES AND COMMENTS.

An Unworthy Trick.

THE police news of several London dailies recently contained the announcement that a doctor, whose name and address were given, had been fined by the magistrate for being drunk and disorderly. The prisoner, we are glad to say, was not a member of the profession, but by giving the name and address of an actual person he was guilty of a peculiarly mean and despicable fraud, and one that we say emphatically should be impossible under any police system. It is difficult to impute blame to the reporters, who merely transmitted in the ordinary course of their duties the name as given in Court; and, indeed, if the unworthy scoundrel who personated the doctor were discovered, it is by no means certain that an action for damages would lie against him. But it surely argues a culpable laxity on the part of the police staff that they should be satisfied with any name given them by a casual "drunk," and the least that they could be expected to do would be to assure a prisoner that he would remain a prisoner till he proved his identity. It is intolerable that the good name of a member of an honourable profession should be liable to be besmirched by any ruffian who gets into trouble by his own folly.

Doctor-Badgering.

ANOTHER hiatus in the police system is its inability to arrange for proper reports being made on patients in hospitals who are required as witnesses. There seems to be no alternative to summoning the house-surgeon to give evidence as to their state of health, which is generally inconvenient, but at least carries a fee with it, or sending a police-officer to make informal inquiries at any hour of the day or night that happens to suit his own convenience. Needless to say, no fee is offered for such visits. Now, house-surgeons are busy men, whose time is fully occupied with important duties, and it is unfair that the State for its own purposes should countenance a system of badgering when proper arrangements could easily be made.

A Case in Point.

LAST week at Birmingham, in the course of a prosecution for malicious wounding, the stipendiary wishing to know the condition of the wounded man, ordered a police constable to make immediate inquiries at the hospital. Dr. Clarke, very properly, refused to disclose information about his patient in this informal way, but intimated that he was prepared when properly summoned to give the necessary evidence. The magistrate, on receiving this reply, sent the constable a second time, and when Dr. Clarke was found to maintain his attitude of reserve, the stipendiary remarked that he would lay the matter before the Board of the Hospital. If as a lawyer, he does not know that Dr. Clarke was acting strictly on legal grounds, the magistrate might, as a man of the world, be aware that gentlemen with responsible duties do not wish to be baited by irresponsible constables. A proper medical report-form carrying a reasonable fee, should be available for such purposes.

Legal Incredulity.

THE law is often said to be no respecter of persons, and it would seem at least that many lawyers are no respecters of doctors. In giving evidence, even in the High Court of Justice, as to a person's inability to appear, a doctor is frequently subjected to ruthless cross-examination by the opposing counsel. It is natural that when an important witness is unable to attend, the side that suffers should say that the illness is greatly exaggerated or altogether feigned, but it is not right that an honest medical man should have to bear the brunt of their discontent. Last week, in the case of the bankruptcy of Mr. F. Horner, Dr. Pelham Maitland had to attend and endure a severe cross-examination, punctuated with laughter, as to the debtor's inability to be present. Fortunately, an independent consulting physician had seen Mr. Horner with Dr. Maitland, and the Registrar was eventually satisfied, but it is difficult to see why the Court should not have its own medical official to report on such cases.

Telephonic Consultations

ALTHOUGH the telephone nuisance has not reached so acute a phase in this country as in others, it is still at times sufficiently annoying. In Vienna the abuse of the system has reached such a point that, in order to put an end to a doubt as to whether a medical man was entitled to charge a fee for advice given by telephone, a case was brought into Court. In this case the patient had on several occasions sought advice over the telephone, sometimes even at night, and for such advice he refused to pay. The result of the case is satisfactory to the profession in Vienna, as the judge decided that advice must be paid for whether given through the telephone

by letter, or in the consulting-room. The special knowledge acquired by a practitioner must not be made the subject of sweating. As it is an invidious matter for one medical man to charge for telephonic advice unless his colleagues all do the same, we learn that it is the intention of the branch division of the medical councils in Vienna to compel their members to charge for such consultations.

Hospital Administration Difficulties.

A CASE illustrating the difficulties of isolation hospital administration was tried at Birmingham County Court last week. A working photographer who had five children, and earned three guineas a week in wages, was summoned by the King's Norton Urban District Council for £30 5s. for seventeen weeks' maintenance of his child in their hospital, while she was suffering from scarlet fever. The local authority in whose district the father lived were apparently unable to make arrangements themselves for receiving the child, and she was consequently sent to the King's Norton hospital. The father being under the impression that the treatment would only last six weeks, seems to have consented to pay £1 15s. a week, and when the bill came in, he found he was saddled with £30 5s.—a serious sum for a man of his means. In the event, the jury, taking a lenient view, let him off with ten guineas, though he would appear to have been liable for the larger amount. Though no doubt there was some misunderstanding, the case undoubtedly presents features of considerable hardship.

LEADING ARTICLE.

HOSPITAL FUNDS AND AMALGAMATION OF SPECIAL HOSPITALS.

LAST week the London City Orthopædic Hospital formally accepted the amalgamation scheme which has been so long urged by the Hospital Sunday Fund. As our readers may remember, the Royal and the National Orthopædic Hospitals had previously joined hands. With the general principle of amalgamation we have little concern, for there is obviously much to be said in favour of the economy of administration that must necessarily be effected by a wise centralisation But approval must, as a matter of ordinary prudence, be qualified with certain clearly-defined conditions. The Metropolitan Hospital Sunday Fund is obviously not justified in forcing a policy of amalgamation upon a group of hospitals without accepting the responsibilities involved in such a proceeding. In the particular case of the London Orthopædic hospitals we venture to think that the public, no less than the medical profession, are entitled to ask whether the Sunday Fund can justify their intervention. First of all, the financial management of the Royal had been the subject of unsparing criticism for several years. The management, under the chairmanship of Mr. H. H. Marks, decided to sell the enormously valuable freehold site of the Hospital, and were casting about for another site, when the amalgamation scheme enabled them to hide their failure in finance by fusing their funds with those of the National. The former site of the Royal Orthopædic in Oxford Street is now covered with expensive flats and shops, but the freehold endowment of this is gone, or will shortly be gone, for ever from the cause of medical charity. Was the Hospital Sunday Fund in full possession of the facts in connection with the sale or the proposed sale of the site of the Royal Hospital? Do they approve the financial judgment of Mr. Marks' committee in the affair? If not, how could they urge amalgamation without an intimate knowledge of the finances of the hospitals involved? The attention of the Sunday Fund was repeatedly called to the proposed sale of the site in the columns of THE MEDICAL PRESS AND CIRCULAR. It is obvious that if the Fund do not inquire carefully into the affairs of institutions upon which they are urging so all-important a step, their amalgamation policy may at any time be made the stalking horse of fatuous financial blunderers. But whatever may be said as to finance, there is another absolutely unjust condition of hospital life that the Hospital Sunday Fund must consider if they wish to maintain their reputation for justice and independence. We refer to the exclusion of holders of Scotch and Irish medical qualifications from hospital posts. The National had that extremely offensive and obnoxious condition as one of their bye-laws, the Royal had not. We believe that the two amalgamated hospitals admitted an Edinburgh Fellow, one of the staff of the Royal, for a limited period as surgeon. We think we are accurate in saying, however, that the amalgamated staff will in future exclude all save London diplomates. At any rate, we hold it to be the bounden duty of the Hospital Sunday Fund to see they have no hand in an amalgamation scheme that permits the perpetuation and extension of so gross an injustice. How does this exclusion affect the City Orthopædic Hospital? In spite of protests that all is well, and that the Charter provides for justice, the opinion of the medical men concerned is clear enough. Mr. John Poland, as a Fellow of the London College of Surgeons, is entitled to a place on the amalgamated staff of the three hospitals. Two of his colleagues, however, able and experienced men though they be, will be excluded because they hold Scotch qualifications. The City Orthopædic Hospital have appended to their acceptance of amalgamation a simple note expressing a hope that their medical staff will be elected instead of the strong, sturdy protest against the injustice of excluding from public posts honourable members of an honourable profession for so poor a reason as the trade union protection of the London Colleges. In the name of ordinary justice we beg the Hospital Funds to see fair play in this matter, and to take care they do not become the cats-paws of self-seeking corporations. It is to be hoped that Scottish and Irish graduates and diplomates will take steps to educate the public on this matter. We feel certain that neither

His Majesty King Edward nor the Prince of Wales would knowingly sanction the perpetration of so great an injustice by the Hospital Sunday or any other Fund under their patronage.

NOTES ON CURRENT TOPICS.

The Royal Victoria Infirmary.

THE magnificent new buildings of the Royal Victoria Infirmary at Newcastle-upon-Tyne were last week formally opened by His Majesty the King. The cost of the Institution has been £300,000, of which £100,000 was given by the late Mr. John Hall, £100,000 by Lord and Lady Armstrong, while the remaining £100,000 was collected by Sir Riley Lord in Newcastle and the district. The site is on the Leazes section of the Town Moor, and of its ten acres the greater part is covered by buildings. The Infirmary is a handsome structure of red brick and sandstone, built on the pavilion system from the designs of Mr. W. T. Newcombe, F.R.I.B.A., and Mr. H. P. Adams, F.R.I.B.A. It has eight ward pavilions, containing 20 wards and 450 beds, the latter being about 200 in excess of the number in the old infirmary. The administrative block occupies a central position, in which ample accommodation is made for committee, honorary staff, students and residents. The wards are arranged to hold 24 beds, each with an allowance of 1,500 cubic feet air space to each bed. There is no need to go into details of construction beyond saying that the whole building is fitted out in a very comfortable style upon the most modern scientific principles. The children's ward contains 46 beds, and is beautifully decorated. The new Infirmary is a building of which the citizens of Newcastle may well be proud.

Mr. Haldane's Scientific Methods.

MR. HALDANE, though a lawyer by profession and a Minister for War by the sport of political circumstances, is a scientific man by bent and education, and a scientific man in the broadest sense of the word. On Friday last, after distributing the prizes at the London Hospital, he gave an address as refreshing to the scientific portion of his audience as stimulating to lay readers. Mr. Haldane recognises that real advance can only be attained rapidly and surely by painstaking elucidation and estimation of the factors of a problem, and the marshalling of these according to a carefully co-ordinated plan. To work thus is to work on scientific lines, to conserve energy, and to beat competitors. This great principle, which should be acknowledged and acted upon in every department of national life, Mr. Haldane showed was nowhere more important than in the study and practice of medicine, and nowhere was it so well recognised. The old ideals and the old methods—empiricism and "muddling through"—may have done well enough in our ancestors' time, but we now live in a new epoch, in which new ideals and new methods are essential to success, and Mr. Haldane sees them sinking more deeply into national life and taking stronger hold of people generally, with each succeeding year. But it was pointed out that no nation stood more in need of so thorough an impregnation with science as the British, for with their extraordinary energy, if an error be committed, they go far before they find out they are wrong, and it is not always easy to retrace their steps. It is a sign of the times, and a comforting one, too, that an important position in the Cabinet, should at last fall to a man to whom modern science is an actual and living guide, and not a tiresome excrescence on the body politic.

International Notification of Disease.

AT the Congress of the Royal Sanitary Institute last week two interesting papers were read in the Preventive Medicine section, both suggesting that a wider view should be taken of the occurrence of infectious disease in various countries. The first of these papers was read by Dr. Fremantle under the title of "Public Health and the Imperial Conference," and in it he argued that the figures and facts about infectious diseases should be freely and officially transmitted between all parts of the Empire, not only as end in itself, but with a view to bringing foreign countries eventually within the arrangement. Dr. Walford's paper—"An International System of Notification of the More Serious Infectious Diseases"—went further, and proposed that all countries should unite in the scheme with a view to mutual benefit. From the strictly scientific point of view, there can be no doubt that much valuable information would be afforded to the epidemiologist by the collection of all notification returns, and the expense would be but small, but it is difficult to argue that any great diminution in the incidence or international exchange of infectious diseases would be likely to occur. Plague and cholera, the two diseases Great Britain is really afraid of importing, are already notifiable between nations, but it is questionable whether, if other diseases were added to the list, advantage might not be taken of the fact seriously to injure British shipping. International notification argues great international confidence, and though the world is becoming more civilised, and Powers are not so shy as they were, there are some at least who have not shown a wholehearted longing to forward British commerce. The British delegates to the 1903 International Sanitary Congress were, we know, opposed to the idea of an international bureau.

Overworking of Nurses.

WE have before us a report of a meeting of the Board of Guardians of the Aston Workhouse Infirmary held last week, containing statements which if accurate, disclose a state of things about which it would be difficult to speak too strongly. A Mr. W. H. Ayles, speaking on the report of the House Committee, said that at the present time a night attendant was in charge of two wards containing respectively eighty and eighty-one patients, and that when the nurse was relieved the patients

were either left in charge of an inmate, or remained totally unattended. Among the 161 cases there were forty-six acute epileptics, some of whom had as many as twelve fits in a night. Some of the patients suffered from dementia and were occasionally violent. The representative of the Committee said that he had nothing to add to what had been said at a former meeting, and that he was prepared to accept full responsibility. The chairman of the Board remarked that he hoped the representative would not regret it, and the reply he received was that the "committee were not so timid as some people." Later it was suggested that an independent committee of inquiry should be appointed, and the chairman of the Infirmary Committee welcomed the suggestion, and admitted that more nurses were needed. He mentioned that the previous week a patient died in great suffering, while the nurse was attending to another seriously-ill case. If the facts be as stated, the sooner an independent committee of inquiry be appointed the better, for we never remember to have read of any worse case of understaffing since the horrors of the Crimean war, and we trust that the attention of the Local Government Board will be duly drawn to the question.

The Salt Sea as a Skin Irritant.

MEDICAL men are often asked as to whether it is wise or not for patients having a sensitive skin to visit the seaside. When there is any acute inflammatory condition, or where the skin is liable to sudden storms of eczematous type it is simply asking for trouble—to use the graphic language of the East End—to visit a salt-laden environment, Then, again, a chronic malady may sometimes be lighted up thereby into an acute fiery outburst. Yet there can be little doubt that on the whole the salt necessarily encountered in the neighbourhood of the sea is a wholesome tonic to the skin. At times—as we all know—it acts as a strong irritant to the healthiest skin, which turns a rich red or brown, and proceeds to peel off incontinently. After this first protest against an unaccustomed irritant, the rebellious skin soon settles down into contented restfulness. Quite possibly, a similar healthy reaction would follow in many so-called "delicate" skins, and the first original damage due to sun and sea-salt could be overcome. To the robust Philistine, both of those powerful seaside irritants act simply as incentives to healthy action, not only of the skin, but of every other organ of the body.

The Dublin Water Supply.

WE published last week a letter in which Dr. McWalter, of Dublin, drew attention to the necessity of periodical bacterioscopic examinations of the water supply of Dublin. There is no doubt that Dublin has in the Vartry water a remarkably pure supply, so pure indeed that in the bacteriological laboratories in Dublin, ordinary tap water is regarded as sterile. This reputation of the Dublin water has probably given those responsible for the Health of Dublin a false sense of security, and the danger to which Dr. McWalter alludes is a very real one. The catchment area has recently been much enlarged, and during the next few months hundreds of workmen will be employed in building reservoirs, and in other work at Roundwood. It is obvious that the water-supply will be exposed to every risk of contamination, and in case of any one of the workmen suffering from typhoid fever or other water-borne disease, the health of the citizens of Dublin will be in imminent danger. It is to be hoped that by having the workmen at Roundwood under efficient sanitary control, every means will be taken to prevent contamination. Nevertheless, if contamination occurs it is obvious that it ought to be discovered at the earliest possible moment. To bring this about, periodic bacterioscopic examination is imperative. We trust that Dr. McWalter is in error when he says that "the Dublin Corporation cannot be got to see the necessity of it." The death-rate of Dublin is sufficiently high without such an epidemic as any carelessness at the present time may bring about.

The R.C.S. and Midwives.

AT the quarterly meeting of the Council of the Royal College of Surgeons of England held last Thursday, the various officers for the year were elected and the professors duly appointed. It was then moved by Mr. Ward Cousins, and seconded by Mr. Godlee that a resolution in favour of the adequate payment of medical men for assisting midwives in dangerous cases be passed. That the College which, up till the present, has so studiously avoided rendering help to its members should now depart from this traditional policy, and actually step into the arena of medical politics, is a sign of grace no less welcome than unexpected. It is perhaps significant that the resolution was proposed by a provincial fellow, but, once proposed, it would have been difficult for the Council to have refused to adopt it. Nevertheless, we congratulate the Council on its first effort towards assisting its *alumni*, and we particularly congratulate Mr. Ward Cousins on the success of his motion. Perhaps some day the College may see its way to bolder things even than registering a pious resolution.

Curious Generosity.

THERE is an odd circumstance connected with the lamented death of that brilliant journalist and politician, Mr. Pakeman, of the Transvaal. Vigorous partisan though he was, Mr. Pakeman possessed the rare power of making his opponents not only respect but actually like him warmly. It is stated that when it was known a little while ago that he was suffering from cancer, one of the Rand millionaires, a well-known sportsman, whom he was constantly opposing in politics, said that he had seen in a newspaper that a new cancer cure had been brought out in America, and he would be glad if Mr. Pakeman would, as his guest, go to New York and undergo the treatment. Though this offer speaks well for the millionaire's goodness of heart, it throws into relief the untold harm that is and may be done by the irresponsible press-booming of pretentious "cures."

The Dangerous Performances Bill.

THE showmen of Merrie England are up in arms now that their vested right of risking the lives of performers is threatened. For many years THE MEDICAL PRESS AND CIRCULAR has advocated the need of putting a stop to these dangerous diversions. From time to time all kinds of terrible deaths have been commented on in our columns. Now it has been some unfortunate performer killed by a lion, alligator, or other wild beast, or at another some luckless wight mangled by a fall in looping the loop, diving from a lofty roof, or some other mad feat. The very existence of deadly performances of the kind shows that there is fascination about the thing which appeals to some deeply-rooted instinct of mankind. Its nature is somewhat akin to the old Roman love of the gladiatorial show and the modern Spanish bull-fight. Anyway, the showmen recognise the value of risky feats in the playbill. Last week they went in formal deputation to Mr. Herbert Samuel, Under Secretary for Home Affairs, to protest against the passing of the Dangerous Performances Bill. Their chief ground was that during the last five years only two serious accidents had happened in 7,800,000 performances. Those two, however, were, in our opinion, the result of totally unjustifiable risks. ———

Death in the Serviette.

AN outcry has been raised on the strength of a pronouncement by Professor Kron, against the necessary, if not harmless, serviette which is the badge of the waiter tribe. In fact, it is the question of harmlessness which is at stake. Is the waiter's serviette a means of conveying disease, or is it not? The probability is that cloths equally dirty, indeed much more so, are used to wipe dishes and plates in the kitchen, but the eye of the restaurant customer not seeing them, his heart does not grieve. The serviette of the waiter, however, is obtrusively obvious, and if the customer, be he professor or man-in-the-street, see it used successively to polish the leg of the table and to give the final touch to his tumbler, the gorge is apt to rise. Everything that makes for cleanliness in habit naturally has the support of the medical profession, and though one should not anticipate any startling changes in the Registrar-General's returns if the serviette were abolished, it might reasonably be replaced by the Japanese paper serviettes which are too cheap to be worth using twice, and too flimsy to stand much that is now done by the linen article.

PERSONAL.

ON July 11th King Edward visited Newcastle-on-Tyne, where he formally opened the new Royal Victoria Infirmary, of which His Majesty, when Prince of Wales, laid the foundation stone on June 20th, 1900.

THE Congress of the Royal Sanitary Institute was opened on the 9th inst. by the Lord Mayor of Bristol, and the Presidential Address was delivered on the evening of the same day by Sir Edward Fry.

SURGEON-GENERAL SIR A. KEOGH, K.C.B., Director-General of the Army Medical Department, presented the prizes and unveiled the South African War Memorial, at St. Mary's Hospital School, London, on Monday last. ———

THE sixty-fifth annual meeting of the Medico-Psychological Association will be held at 11, Chandos Street London, W., on the 26th and 27th instant, under the presidency of Dr. Robert Jones. The annual dinner will take place on the evening of the 26th at the New Gaiety Restaurant.

DR. LENNOX LINDLEY, formerly Assistant Physician, has been appointed Physician-in-Chief to the Shah of Persia, a post recently held by Dr. Schneider, a French physician.

SIR JAMES CRICHTON-BROWNE will deliver the Opening Address to the students of the Leeds Medical School in October next.

A PRESENTATION consisting of a handsome marble clock and ornaments was made to Dr. Morris, medical officer of health for Neath, on the occasion of his wedding. The Mayor on behalf of the officers of the Corporation made the presentation.

MME. CURIE, who was approached with reference to a joint testimonial to her husband and herself, has replied to her admirers that M. Curie was so much opposed to the usual ways of honouring the dead that she hopes no such project will be entertained.

DR. Dow, on the occasion of his retirement after fifty years' practice in Dunfermline was last week presented with a handsome silver testimonial from his friends and patients.

To celebrate the twentieth year of his Professorship of Gynæcology, Dr. Samuel Pozzi was presented with a specially designed gold medal, and a "golden book," containing unpublished articles on gynæcology by leading men. Dr. Debove, Dean of the Faculty of Medicine at Paris, took the chair at the ceremony.

PERMISSION has been granted by the King to Dr. H. Nolan, medico-legal adviser to the Egyptian Native Tribunal, to accept the Order of the Medjidieh, 3rd Class, conferred on him by the Khedive.

THE Government grant for successful vaccination has been awarded for the second time in succession to Mr. Legh Richmond Marshall, Public Vaccinator for the Mary Tavy District of the Tavistock Union.

DR. EDWARD CARNELL was recently presented with a testimonial in the shape of a handsome paper-knife by the members of the Harrogate Branch of the St. John's Ambulance Association, as a token of their gratitude for his services.

THE King has granted permission to Dr. W. St. C. Symmers, formerly Professor of Pathology in the Egyptian School of Medicine, and now Professor of Pathology in the Queen's College, Belfast, to accept the Order of Medjidieh, Third Class, and the Order of the Osmanieh, Fourth Class.

DR. JOHN F. W. TATHAM, M.D. (Univ. Dub.), M.D., F.R.C.P.Lond., Superintendent of Statistics, General Register Office, London and President of the Epidemiological Society, has been elected an Honorary Fellow of the Royal College of Physicians of Ireland.

DR. HOWARD KELLY, who has just added to his literary output a memorial volume on the work of the late Dr. Walter Reed, is, we believe, to visit this country again in the autumn. Dr. Reed, it will be remembered, died during his strenuous efforts to work out the pathology of yellow fever.

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A CLINICAL LECTURE
ON
PSOAS ABSCESS: ITS NATURE AND TREATMENT, WITH NOTES OF AN ILLUSTRATIVE CASE.*

By C. YELVERTON PEARSON, F.R.C.S., F.R.U.I.,
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GENTLEMEN,—The patient to whose case I wish to direct your attention to-day is one on whom you saw me operate for psoas abscess just three weeks ago.

The case is one which presents some peculiar points of interest:—(1) He is older than the usual class of such cases we meet with; (2) he never gave any indication that he had suffered from spinal mischief; (3) his symptoms were referred almost entirely to the region of the hip-joint; and, (4) a number of the senior students, to whom I submitted the case at a recent clinical examination, all diagnosed hip-joint disease; whilst only one of the five who examined him recognised that he was suffering from psoas abscess. Before dwelling on the aspects of this particular case I think it well to review the subject of psoas abscess in a general manner.

Definition.—Psoas abscess is a collection of pus, confined in the first instance by the fascial sheath of the psoas magnus muscle, extending after a time beneath the fascia of the iliacus and later on in other directions. As ordinarily met with it may be defined as a chronic abscess in the psoas sheath resulting from and symptomatic of tubercular osteo-myelitis of the lower dorsal or the lumbar vertebræ.

Mode of Origin.—Suppuration may arise within the psoas as the result of injury and idiopathic infection, with pyogenic micro-organisms; it usually results from spinal caries of the lower dorsal or upper lumbar vertebræ. It is not often met with before puberty, generally between that period and thirty years of age; it is more common in males than in females, and is more likely to form in spinal caries if the patient has been going about during the early stages of the disease. Again, a psoas abscess may result from suppuration of tubercular lymphatic glands in the posterior mediastinal space, or in rare instances be due to the escape of pus from an empyema into the posterior mediastinum The matter in such cases entering the sheath of the psoas beneath the *ligamentum arcuatum internum* of the diaphragm. An iliac abscess proper may, by extension, involve the psoas, or an abscess in the psoas may be the result of sacro-iliac disease; finally, in exceptional instances, the sheath of the psoas becomes involved by extension from disease of the hip joint first to the bursa beneath the psoas tendon and from that to the sheath of the muscle itself.

Anatomical Characters.—The course of a psoas abscess will be best understood by first considering the disposition of the fascia forming the sheath of the muscle. It is derived from the fascia iliaca of the abdomen. This is a dense fibrous membrane which covers the iliacus muscle, being attached externally to the whole length of the inner border of the crest of the ileum, passes over the psoas and is attached internally to the brim of the pelvis. Below, it is intimately connected with the portion of Poupart's ligament which is external to the line of the external iliac vessels. Behind the vessels it descends into the thigh and forms the posterior wall of the femoral sheath. At the inner side of the vessels it is attached to the ilio-pectineal line behind the conjoined tendon. It becomes continuous with the transversalis fascia on the inner and outer sides of the external iliac vessels. The portion in relation with psoas magnus muscle is attached internally to the base of the sacrum, the upper and lower margins of the bodies of the lumbar vertebræ and the intervertebral discs, thus forming tendinous arches over the concavities of the bodies of the vertebræ. These arches give origin to the psoas muscle, and transmit the lumbar vessels and branches of the sympathetic nerve. Above, it forms the *ligamentum arcuatum internum.* Below the crest of the ilium the psoas portion of the iliac fascia becomes continuous externally with the portion which covers the iliacus muscle; the two muscles being only separated by delicate connective tissues. Above the iliac crest it is attached externally to the anterior layer of the lumbar fascia near the tips of the transverse processes of the vertebræ.

At the point where the iliac fascia is attached to the ilio-pectineal line it is indirectly continuous with the pelvic fascia. Internal to the psoas it is also attached to the capsule of the hip-joint and to the upper ramus of the pubis, becoming continuous with the pubic portion of the fascia lata. Opposite the outer half of Poupart's ligament the iliac and transversalis fascia blend, and are there closely united to that ligament. Beneath the inner part of the ligament they do not blend but are separated by the blood vessels and continue downwards upon them to form the femoral sheath. Below Poupart's ligament the iliac fascia continues to cover the psoas and iliacus muscles and the anterior crural nerve.

In caries of the upper and middle dorsal when pus forms, owing to the resistance offered by the parietal pleura, it is usually directed backwards through the intercostal spaces following the course of the dorsal branches of the intercostal vessels and gives rise to a dorsal spinal abscess. In the lower dorsal region, owing to the absence of the pleura the pus passes downwards by the side of the aorta and enters the sheath of the psoas on one or both sides beneath the *ligamentum arcuatum internum.* Suppurative caries in the dorso-lumbar or lumbar region will give rise to a lumbar abscess when the pus is formed behind the attachment of the anterior layer of the lumbar aponeurosis; to a psoas or ilio-psoas abscess when occurring beneath the limits of attachment of the iliac fascia; and to a pelvic abscess when situated between or below the internal attachment of the iliac fascia on either side. When pus enters the sheath of the psoas the matter passes down the whole length of the muscle destroying many of its fibres partly by suppuration and partly by ulceration. Later on it extends outwards beneath the iliac fascia, destroying much of the substance of the iliacus muscle, and becomes an ilio-psoas abscess. The exact situation at which this extension occurs is not very clear. Owing to the disposition of the fascia, which I have already described, extension might occur at any point below the iliac crest. But in all probability it does not usually take place until the matter meets with the increased resistance offered by the narrowing of the sheath where the two muscles become conjoined.

A psoas abscess is usually more or less multilocular It may be single or double. The double variety, as I have already indicated, usually resulting from disease in the lower dorsal region, but possibly originating, in some instances from bilateral disease of the lumbar vertebræ.

The contents of the abscess vary in character, but as in the case of chronic abscesses in general, true pus is absent. They may be serous or sero-purulent with caseous masses, and in most cases fragments of carious and necrotic bone. In old-standing cases, owing to

*Delivered in the North Charitable Infirmary, Cork, May 28th, 1906.

the absorption of the more fluid contents, the residuum may consist of cheesy and calcareous matter.

Tubercle bacilli can occasionally be detected, though the fluid usually proves sterile on attempts at culture.

Course and Terminations.—When following an anatomical course, a psoas abscess leaves the abdomen beneath Poupart's ligament outside the vessels, it then passes beneath them towards the lesser trochanter. If the iliac portion passes out separately, it forms a swelling external to the artery. If the swelling is large it may conceal the femoral vessels; sometimes it pushes them forwards so that the vein is compressed and the artery beats subcutaneously. In some instances the abscess may expand in Scarpa's space forming its own sac, and then varies much in character. When small, it may simulate a femoral hernia; when large, it may appear double from an oblique depression produced by the crossing of the Sartorius muscle. It may then pass outwards along the course of the external circumflex vessels under the *tensor fascia femoris* and open over the great trochanter.

Usually after reaching the thigh the abscess extends downwards on the outer side of the femoral vessels till it reaches the origin of the profunda artery, and following the course of that vessel passes under the femoral vessels.

It then continues its course beneath the adductor longus forming a large swelling at the inner side of the thigh, having the adductor longus in front, the adductor magnus behind it, and the gracilis stretched over its inner side. It often happens that processes extend from the main cavity along the branches of the profunda, the most common being one following the internal circumflex winding round the neck of the femur and passing backwards through the interval between the quadratus femoris and adductor magnus, and eventually pointing in the interval between the ischial tuberosity and the great trochanter. As a rule the abscess does not extend beyond the upper part of the thigh, but it may extend to the popliteal space, down the back of the leg, and even along the posterior tibial vessels as far as the heel.

A typical and fully developed psoas abscess consists of four principal parts, a narrow track in the upper part of the psoas, an expanded sac in the iliac fossa, another narrow portion beneath Poupart's ligament, and a large cavity on the upper and inner part of the thigh.

The favourite situation for a psoas abscess to point is in the upper adductor region; it may, however, point in many other situations some of which I have already indicated. Occasionally, it points above Poupart's ligament, above the iliac crest, or in the lumbar region. It may open into a viscus such as the bladder or bowel. It has been known to open into one of the large arteries (aorta or iliac) in its vicinity. In exceptional cases by following the course of the lumbo-sacral cord it may reach and pass out through the great sacro-sciatic foramen and form a gluteal abscess. It is stated that a psoas abscess may pass the pelvis by raising the attachment of the iliac fascia from the brim of the pelvis and passing down on the outer aspect of the pelvic fascia reach the ascro-sciatic foramen or the ischio-rectal fossa. Owing to the very firm attachment of the fascia at the pelvic brim I believe this to be an exceedingly rare occurrence. In the majority of cases where pus makes its way into the pelvis as the result of carious disease in the lumbar region, it does so by passing down behind the peritoneum in the interval between the origin of the psoas muscles of opposite sides over the promontory and along the concavity of the sacrum till it reaches the fascia covering the pyriformis muscle, after which it may pass outwards through the sacro-sciatic foramen or in other directions.

A psoas abscess may gradually subside owing to absorption of the more fluid contents and the deposition of earthy salts in the caseous material. Such dried up abscesses sometimes suppurate later on and give rise to what has been termed a residual abscess by Paget. When a psoas abscess bursts spontaneously it usually does so through a small opening: a gush of seropurulent fluid takes place and the opening becomes blocked with cheesy flocculi; these after a time are displaced and a fresh escape of fluid occurs. In this way gradual evacuation may take place without the admission of infective micro-organisms and recovery ensue without constitutional disturbance. When free evacuation occurs or is brought about in the absence of aseptic precautions infection of the sac takes place, followed by acute suppuration with its attendant evils of pyrexia, sapræmia, possibly pyæmia, or a prolonged course of suppurative fever ending in exhaustion or albuminoid degeneration. Such are the natural courses and terminations of this affection.

Diagnosis.—We must now consider the question of diagnosis. This is usually not a difficult matter in fully developed cases, but for its most successful treatment the affection should be recognised whilst intra-abdominal. Subjective symptoms may be absent altogether the extra-abdominal tumour first attracting attention. Early symptoms depend upon the irritation of the lumbar nerves close to the spine which may give rise to pain in the lumbar or iliac regions, or in the course of the anterior crural or sciatic nerves; pain in the region of the hip or sacrum; inclination forwards when standing; internal rotation of the thigh, inability to completely extend the limb, &c.

Inspection and palpation reveal the presence of an elongated vertical swelling in the lumbar region extending into the iliac region or as far as Poupart's ligament. It is elastic or fluctuating, dull on percussion, does not roll from beneath the fingers or alter its position with the posture of the patient, and may be associated with a swelling of similar character in the iliac fossa. Examination of the spine will usually afford evidence of Pott's disease.

When the abscess becomes extra-abdominal, there is a fluctuating swelling in the upper part of the thigh which has an impulse on coughing, is incompletely reducible, and the sense of fluctuation can be transmitted from the portion below to the portion above Poupart's ligament.

The intra-abdominal form of psoas abscess has to be differentiated from overloaded bowel, from iliac or perityphlitic abscess. The extra-abdominal swelling from hernia, from abscess due to hip disease and from the various swellings which may occur in Scarpa's triangle, &c. Time does not permit me to enter into the distinguishing characters of each of these affections, so that I must pass on to the subject of treatment, but before doing so I shall relate the particulars of the case now under consideration, for the notes of which I am chiefly indebted to the observations of those of you who examined the patient previous to operation.

History.—The patient, a farmer, æt. 24, of fairly healthy aspect, was sent to me by Dr. Wm. MacSweeney of Killarney on April 30th. He first complained of pain in the right hip three months ago. He had three or four attacks of pain shooting down to the knee and foot. There was no tenderness over the course of the sciatic nerve. Three weeks ago he began to limp on the right leg and had to give up work. There was no history of injury nor of any previous illness. The family history is good.

Physical Examination.—The patient stands with his right heel raised, the right foot slightly advanced and the toes slightly everted, the hip is very slightly flexed and the pelvis slightly lowered on the affected side.

When lying down, complete extension of the limb produces an almost imperceptible degree of lordosis. Careful measurement from the anterior superior iliac spine to the tip of the internal malleolus shows no difference in the length of the limbs of opposite sides. Measurement of the circumference of the thighs shows no evidence of wasting. The right hip can be moved in all directions with only a slight degree of pain on complete extension or abduction. The pelvis does not move with the thigh. There is no pain produced by

hitting the heel in an upward direction or on pressing the iliac crests together. Some pain is felt on pressing over the great trochanter, but this is superficial in character and follows the course of the cutaneous nerves.

Pain is also produced by pressure on the anterior crural nerve. There is a slight fulness immediately below Poupart's ligament. A marked swelling is felt above Poupart's ligament in the iliac fossa and extending up to the ribs on the right side. This is elastic, slightly fluctuating and offers marked resistance to pressure as compared with the opposite side. No resonance on percussion is present on the right side, except beyond the limit of the swelling. On examination of the back a distinct prominence of the spine of the eleventh dorsal vertebræ is perceptible. There is no tenderness on pressure or percussion over any portion of the spinal column, nor any evidence of active spinal mischief.

It was only by the most careful cross examination that a history of pain in the back and along the course of the lower ribs was elicited. This was noticed three years ago, but did not interfere with the patient following his usual occupation.

Diagnosis.—As I pointed out to you, previous to operation, the symptoms and physical signs justified the diagnosis of psoas abscess dependent on old standing caries of the lower dorsal vertebræ which had become quiescent. The freedom of movement at the hip-joint combined with the absence of wasting of the muscles, and of marked lordosis excluded hip-joint disease.

Treatment.—The patient was operated on May 7th, in the following manner :—An incision was made four inches in length commencing about an inch below, and internal to the anterior uperior iliac spine and terminating below the twelfth rib. All the muscles were divided to the full extent of the superficial incision, then the fascia transversalis ; the peritoneum and intestines were now pushed forwards and inwards, the iliac fascia was pierced with a pair of sinus forceps, and, on opening the blades, pus, of the usual character found in chronic abscesses, escaped freely. Two fingers of the left hand were then introduced, the opening in the fascia extended and the cavity carefully explored in every direction. It was then thoroughly flushed out with a hot solution of mercuric biniodide 1 in 2,000, all débris and caseous material being removed with the aid of the fingers. The vertebræ were carefully explored with the fingers and probe, to ascertain the presence of existing disease, with negative result. The entire cavity was now carefully wiped out with pieces of dry sterile gauze held in sponge forceps. After this, the interior of the cavity was carefully swabbed over with a 1 per cent. watery solution of iodine. Six deep sutures of silk-worm gut were passed through all the divided strata. Before these were tied careful pressure was made over the entire abscess sac so as to bring its walls in contact and expel any air. The sutures were then tied, a dressing of dry sterile gauze was applied over the wound, and pressure was maintained by means of pads placed over the line of the right semi-lunaris and iliac fossa.

You now see that since the operation there has been no disturbance of temperature save a rise to 100° F. during the first twenty-four hours due to aseptic fever, resulting from the necessary but slight extravasation of blood. The wound is perfectly healed, the sutures have been removed, and there is no evidence of refilling of the cavity. (*a*)

I shall now enumerate and briefly discuss the chief methods of treatment that have been employed for the treatment of psoas abscess. These are as follow :—

The expectant or non-operative, repeated aspiration, free incision and drainage, tapping with a large trocar and cannula, washing out and injection of iodoform emulsion, free incision, followed by scraping with a flushing curette with or without drainage, and incision, thorough cleansing of the cavity and sewing up.

As I have already pointed out to you, treatment by rest alone may result in spontaneous cure. Previous to the development of antiseptic and aseptic methods this was the treatment that surgeons were led to adopt owing to the disastrous results which usually followed upon operative interference from secondary infection of the cavity through the admission of micro-organisms. At the present day, it is often wise to treat the patient by rest in the recumbent posture before resorting to operative measures, but it is unwise to wait once an abscess has fairly developed, lest it should extend beyond the limits of the abdomen.

Of operative measures, aspiration alone cannot be recommended, as frequently the needle of the aspirator becomes blocked with caseous matter and in any case the cavity cannot be thoroughly emptied. Treatment by free incision and drainage under the antiseptic system was introduced by Lister and often gave excellent results, but the treatment by drainage is open to one very grave objection, viz., the very great danger that exists of infection taking place even with due precautions, owing to the possible infection or displacement of dressings. The treatment by tapping with a large trocar and cannula, followed by thorough washing out with hot saline solution and the injection of iodoform emulsion has many advocates. It is, however, open to the objection that it does not completely evacuate the contents and that there is some risk of iodoform toxæmia ; whilst even its most ardent supporters admit that a cure is only occasionally obtained in this way by one tapping, and that more commonly the fluid re-collects and the same process has to be repeated two or three times. The method of curetting with a sharp spoon is one that I cannot approve of, it injures the tissues unnecessarily, starts bleeding into the cavity and opens up fresh fields for infection with tubercular material if spinal disease be still active.

The treatment I have employed in the present case is one that I have successfully used on several occasions and I cannot recall a single instance of failure since adopting it several years ago. I find that it is practically identical with the method advocated by Mr. Tubby (Green's "Encyclopædia Medica"), who recommends the introduction of a solution of menthol, 1 drachm dissolved in 1 oz. of alcohol, which is added to and mixed with one pint of glycerine. Personally, I have every confidence in a solution of iodine as an application after the cavity has been thoroughly cleansed. It must be remembered, however, that if necrosis is still going on in the vertebræ, a re-collection of pus is almost certain to take place, no matter what method of treatment is adopted. The points which I wish particularly to emphasise are : (1) free incision or incisions in suitable situations ; (2) thorough cleansing of every part of the cavity ; (3) arrest of hæmorrhage ; (4) the application of iodine or some reliable non-irritating disinfectant to the interior of the sac ; (5) the obliteration of the cavity by pressure ; (6) thorough closure of the wound by sutures ; and (7) the observance of the strictest aseptic precautions.

In some instances it may be necessary to make two or more incisions, such as one in the loin one in the iliac region, and one below Poupart's ligament. The one large ilio-lumbar incision which I have described is usually sufficient to enable the operator to reach all parts of the abscess cavity and gain access to the diseased part of the vertebral column.

The general treatment of the patient must be attended to in all cases. This will consist of the administration of such remedies as iodide of iron and cod-liver oil, free and nutritious diet and open air treatment.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week's issue will be by J. Odery Symes, M.D., London, Bacteriologist and Assistant Physician to the Bristol General Hospital, on "Chronic Rheumatism and Rheumatoid Arthritis."*

(*a*) The patient returned home June 9th.

ORIGINAL PAPERS.

PULSE TENSION: ITS CLINICAL SIGNIFICANCE.*

By H. W. SYERS, M.A., M.D.CANTAB.,
Physician to the Great Northern Central Hospital.

(Concluded from our last No.)

PART II.

I will now consider in the light of the history of a few cases some of the abnormalities ascertained to exist by means of the Riva-Rocci instrument.

In Addison's disease, the pulse tension is extremely low; in a case I had in the wards some months ago it fell to 35 mm., being the lowest I have yet seen. The case was a very advanced one, and the patient died about a fortnight after admission. It is worthy of mention that the administration of adrenalin had not the slightest influence in raising the blood pressure.

Low tension of pulse may be almost the one feature which suggests the possibility of a case being one of Addison's disease. We are occasionally confronted with youthful patients whose one complaint is of increasing feebleness on exertion. On examination, extreme feebleness of pulse may be recognised. Such patients are pale and may be extremely anæmic, but there is no evidence of pigmentation. The possibility of the case being one of Addison's disease should certainly be borne in mind, for not seldom in this malady the essential feature, weakness of circulation, may considerably antedate the onset of morbid pigmentation.

In pernicious anæmia the pulse tension is also much below the normal. In a case under my care not long ago it was 87 mm. In this case the heart was diagnosed as fattily degenerate, and the diagnosis was confirmed *post mortem*.

The pulse tension in so-called functional albuminuria is invariably low according to my experience. Last summer I had a case of this description under observation for some weeks. The patient was a boy of 14, whom I first saw in the out-patient room. There was a considerable quantity of albumen, but no evidence of renal disease could be made out. Next time there was no albumen. Some days it would be present, others absent, and he was then sent into the hospital for closer observation. The blood pressure, kindly and most carefully taken by Dr. Clarke, senior house physician, varied from a maximum of 100 mm. to a minimum of 75 mm. But it is important to notice that no relationship whatever could be traced below lowness of pressure at a given moment and the occurrence of albuminuria.

Thus there was no albumen at 100 mm., but it was also absent at 80 mm.; it was repeatedly present at 95 mm., and again absent at 75 mm. Hence it seems clear that the presence of this form of albuminuria is not dependent exclusively upon blood pressure.

In cases of renal disease still in the acute stage, with hæmaturia, such being chiefly children, frequent observations on the arterial tension are very desirable; in this way we can ascertain whether the condition is becoming chronic, and the prognosis will thus greatly depend upon the result of these observations. I constantly employ the Riva-Rocci instrument in such cases, and with the greatest benefit.

The following case illustrates the by no means unusual combination of shortness of breath and œdema due to failing renal heart and high tension. The patient was a woman, æt. 54, who for some months had suffered from increasing shortness of breath, and œdema of the lower extremities. The pulse tension registered 165 mm., the action of the heart was cantering and very irregular. In spite of continued rest in bed the lower extremities remained very œdematous. A certain degree of relief was obtained by the use of iodide of potash and liquor trinitrini, but the dyspnœa was increased and the general symptoms were aggravated by the employment of digitalis. This case clearly shows that, in spite of loss of compensation, the pulse tension may remain high; it continued more or less unduly elevated up to the time of the patient's death.

There can be no doubt that chronic heart disease, and more especially that which is combined with arterio-sclerotic change, often tends to the production of the emphysematous condition. This is the reason why, in such cases, it is often quite impossible to determine the area of superficial cardiac dulness, and it is worthy of notice that other sclerotic lesions may be present in cases of this form of degeneration of arteries.

Not long ago I saw a woman whose pulse tension was much increased and who was also suffering from fibrosis of the left lung, leading to much contraction of that side of the chest. There was also albuminuria and other evidence pointing to the presence of granular kidney. There can be no doubt that in this case there was a general fibrosis of organs, and the process which had attacked the arteries was merely the manifestation of a general morbid tendency.

It is important in all cases of arterial degeneration to be on the look-out for other evidence of cirrhotic alteration in the organs, for I am convinced that the change is not seldom a general one and may be regarded as the premature appearance of that degeneration which in extreme old age is found to affect every organ and tissue of the body—a change which transforms the whole structure into a connective tissue.

Another instance is one of arterio-sclerosis in a soldier, as the result of hardship in the South African war. He was admitted for chronic dysentery. The Riva-Rocci instrument gave a reading of 168 mm., and a faint systolic murmur was audible at the heart apex and the aortic base, extending to the right clavicle. In a case such as this the Riva-Rocci instrument is of the utmost value. It is often difficult to estimate the precise significance of a systolic murmur at apex and base in middle-aged persons, with no antecedent rheumatic history. But when the Riva-Rocci reading is found to be abnormally high, there can be no question that the murmurs are due to atheroma of the aortic and mitral valves respectively, and hence appropriate treatment should be at once inaugurated, in order to avoid the onset of the disastrous consequences of chronic high arterial tension.

In cases such as this it must never be forgotten, in forming a prognosis, that the conditions affecting the root of the aorta which give rise to a systolic murmur are just those which may lead to a stenosis of the coronary artery. Thus the mere fact of a systolic basic murmur being present, and which is due to degenerative aortic disease, may be an indication of the not remote and sudden occurrence of angina pectoris by which life may be brought to an end.

Hence it follows that the presence of atheroma of the ascending aortic arch should never be regarded otherwise than as a serious lesion.

A middle aged man with renal disease became suddenly unconscious, and it was, of course, of the first importance to determine the cause of the seizure. In a case such as this, the blood pressure may be a reliable aid in the diagnosis, should the pressure be high (in this instance it was 200 mm.), it may be confidently affirmed that cerebral hæmorrhage is the lesion actually present, and so it was found in this case. A timely venesection may be of great service in such a condition.

On the other hand a girl, æt. 16, suffering from malignant endocarditis with mitral systolic murmur, was the subject of a seizure in which consciousness was completely lost for many hours and in which also more or less generalised convulsions were present. The Riva-Rocci instrument showed a pressure of 87 to 90 mm., in other words arterial tension was greatly reduced. At the *post mortem* examination it was found that the lesion was embolic arterial plugging, with consecutive softening of the right frontal globe.

These cases, both of recent occurrence in the wards of this hospital, show the value of pulse tension observations in the diagnosis of conditions in which

unconsciousness is a prominent symptom. I need scarcely point out that the treatment applicable to the case of cerebral hæmorrhage would be wholly inadmissible in a case of embolism or thrombosis in which the symptoms are very similar, so much so, indeed, that, without the aid of the sphygmomanometer it might be impossible to differentiate them.

A case such as the following presents itself: A man of 70 complains of shortness of breath, especially on exertion, and a troublesome cough. On examination, he is found to be the subject of marked chronic bronchitis and emphysema, and the heart is dilated, its action being irregular.

The radial arteries are sclerosed in the highest degree, but in spite of the feeble action of the heart, the blood pressure registers 155 mm. Albuminuria is present, and it is clear that the correct diagnosis is that of granular kidney, with extreme arterial degeneration and failing compensation on the part of the heart.

How is this case to be treated? If digitalis is ordered it is obvious that the already greatly increased peripheral resistance will be still further augmented, and thus an increased strain will be thrown on the labouring heart. Further, digitalis at the best, can only whip up the failing organ to increased efforts, of which it is probable it is already more or less incapable through mural changes. It seems tolerably clear that digitalis, at all events given by itself, is ruled out in a case such as this. Far more reasonable would seem to be that form of treatment which, by reducing the peripheral resistance, should enable the feeble heart to forward the blood with greater ease through the peripheral vascular system. In other words, the employment of the vaso-dilator drugs would appear to be clearly indicated.

Of these iodide of sodium would probably be the first made use of, and with satisfactory results. It must not be forgotten that in cases such as these, the progress of arterial sclerosis is far advanced, the elasticity of the arterial wall is a thing of the past, and the great thickening of the same offers a mechanical impediment to the passage of the blood. Hence it follows that the dilating mechanism is altogether and hopelessly out of gear. It is well in such cases to test the effect of liquor trinitrini in one or two minim doses, for the greater the fall in the arterial pressure, within reasonable limits, the more favourable is the prospect of treatment.

I am convinced that the routine administration of digitalis and of other drugs of the same nature in this very commonly met with class of case does nothing but harm. On the other hand, much relief to the distressing symptoms may result from the administration of small doses of liquor trinitrini, of tetranitrate of erythol, or of iodide of sodium. It is another question as to the advisability of ordering such drugs as these merely for the purpose of reducing tension and keeping it permanently low. That it is possible to do this I entertain no manner of doubt, but as to the wisdom of the procedure I am more sceptical. Each case, it seems to me, must be treated on its merits. When very high tension is present, and still more when disastrous evidence of its existence has been furnished by cerebral hæmorrhage, then, indeed, there can be no hesitation as to the expediency of reducing pressure in as permanent a manner as possible. I may instance the case of a woman, æt. 64, who came to the hospital with the very high tension of 250 mm. on the Riva-Rocci instrument, she had a week or two previously awakened in the morning with inability to speak clearly. The case was obviously one of amnesia due to slight hæmorragic effusion probably beneath Broca's convolution. There was considerable degeneration of the radial artery. This patient was put on 10 grain doses of iodide of potash with the result that in a few days the arterial tension fell to 220 mm. A 2 minim dose of liquor trinitrini brought down the tension nearly 20 points in less than half an hour. She was afterwards treated with small doses of liquor trinitrini and finally left the hospital with a tension of 175 mm. only. I repeat that, under such circumstances, there can be no question as to the desirability of doing all in one's power to reduce arterial tension in order to avoid further hæmorrhage, or other complication. The case is widely different when merely increase of blood pressure is observed, without any definite symptom such as dyspnœa or other uræmic manifestation. It is quite certain that the increased tension is an effort of nature to avoid further troubles, and as such I think in the majority of cases that it is best to confine our efforts to the hygienic and dietetic management of the condition, eschewing the use of vaso-dilator drugs, or at all events confining this mode of treatment to the employment of the iodides.

I have already referred to the patient suffering from chronic dysentery, but who was also found to be the subject of atheroma and high arterial tension. The dysenteric symptoms were not at all acute, but he complained from time to time of somewhat severe pain in the upper abdomen.

When seen on one occasion the customary pain was unusually severe and continuous; it was, too, located higher than usual, being chiefly felt across the epigastrium. The pulse tension was found to be 180 mm., and, as the pain did not appear to be directly the result of the intestinal disorder, it was thought that perchance the increase of arterial tension might be to some extent, at least, responsible for the symptoms.

Two minims of liquor trinitrini were given; in about a quarter of an hour the pulse tension had fallen from 160 mm. to 125 mm. or 35 mm. relief was obtained almost immediately. Forty minutes after the administration of the drug the tension was still 125 mm., the patient was then entirely free from pain, though he had been suffering acutely for many hours previously. There can be little doubt that in this case the determination of the pulse tension led to the adoption of appropriate treatment, for it seems clear that the distress in this instance was the result, not of chronic dysentery, but of a pseudo anginal attack associated with arterial degeneration and high tension.

It is of importance to notice the extent of the fall of pressure in this case. A drop of 35 mm. in a few minutes proves that there must still be a considerable degree of elasticity as regards the arterial walls; in other words, these are not the seat of an extremely marked degenerative process.

In another instance, one in which the peripheral vessels were absolutely rigid and pipe-like, the pulse tension being 190, the administration of two minims of liquor trinitrini was followed by no definite fall.

In the case of a man, æt. 50, suffering from chronic nephritis in its most advanced stage and manifesting marked renal dyspnœa, a two minim dose of liquor trinitrini reduced arterial pressure from 196 mm. to 185 mm., in about 5 minutes. Half-an-hour afterwards the pressure was still 185 mm. Two days afterwards the same dose produced no definite fall, and a negative result ensued also at the next trial.

I may incidentally remark that, after venesection to 20 ozs. the blood pressure was as high as ever next day, varying from 190 mm. to 200 mm., and slightly over. This was in spite of his having taken three minims of liquor trinitrini three times a day. In this case there was extreme degeneration and rigidity of the arterial wall, and hence probably but little structure remained on which the drug could act. On the other hand, in a man of 42, suffering from hepatic cirrhosis and ascites, a pulse tension of 160 mm. was present. Iodide of potash in 5 grain doses was ordered three times a day, and in a few days the tension had fallen to 140 mm.

There has been, and is, considerable difference of opinion as concerns the power of the iodides of potash and soda to reduce arterial tension, but the examples already given will, I think, leave no doubt in the mind of the unprejudiced observer as to the ability of the iodides to perform this pressure-reducing function. As a final example I may cite the case of a patient

suffering from early G. P. I., with arterial degeneration, in whom the tension on admission was 170 mm.: After some days' treatment with iodide of potash, pressure fell to 138 mm.; after further treatment, in a fortnight's time the pressure fell to 120 m.m., and kept at this level.

No doubt the rest in bed and careful dieting of hospital patients suffering from high arterial tension have something to do with the fall of pressure; but if treatment with the iodides be withheld for a week or so after the admission of the patient, the results will undoubtedly lead to the conviction that the drug treatment is the main factor in the lowering of arterial tension which almost invariably results.

Arterial sclerosis is an incurable malady; it is much better to accept this fact and to cease to look for remedies which will cure a condition incapable of being amended. All we can do is to palliate the affection and endeavour to arrest its progress. The chief points to attend to in order to attain these ends are to carefully regulate the hygienic conditions under which the patient lives, to cut off all indulgence in tobacco and stimulants, so far as may be possible, to ensure the absence of worry and anxiety, and to see that the patient uses plenty of drinking water. The latter is an important point and I am convinced that much of the gouty and uric acid tendency observed at the present day is due to this omission.

The dietary in cases of arterial degeneration and in high arterial tension is a matter of extreme importance. Yet it is the greatest possible mistake to suppose that these patients must be fed entirely by rule. Far too much attention is devoted at the present time to the feeding of patients on what may be termed physiological principles, the attempt to reduce the diet and so arrange it that such and such a number of units, and no more, of nitrogen, &c., are consumed. These and like efforts are foredoomed to failure, for they do not take into account that most potent influence affecting the human economy—idiosyncrasy.

Spa treatment is often very efficacious. Harrogate is a very suitable spa for the treatment of cases of morbid arterial tension, and both the baths and waters are of much use in dealing with the lesion and its attendant maladies. Doubtless the regulated life at health resorts is a powerful agency in bringing about the favourable results which certainly ensue, but it is impossible not to attribute active therapeutic effects to such potent waters as the saline sulphur springs of Harrogate and other similar spas. Be this as it may, it is certain that many gouty, overfed patients with increased arterial tension derive the greatest benefit from treatment at Harrogate and other mineral springs.

There are certain abnormal cardiac conditions which are not infrequently found to accompany states of high arterial tension and degeneration. Hypertrophy of the left ventricle is the rule, but a dilated state of the cavities is not at all unusual, and, as I have already pointed out, the onset of very marked and pronounced dilatation does not by any means imply the necessary occurrence of low tension. On the contrary, in such circumstances the tension may continue very high, 180 mm. and higher.

That degeneration of the heart muscle should accompany the morbid elevation of tension is only what might be expected; it is by no means uncommonly found, and in my experience it is chiefly fibrous degeneration which is met with. It is particularly well-marked in the papillary muscles of the left ventricle.

As regards fatty degeneration, I am bound to say that it is far more often diagnosed than found in the *post mortem* room. No doubt it is most difficult, indeed, wholly impossible in most cases, to be certain of the presence of this form of heart decay, and there can be no doubt, as pointed out by the late Dr. Balfour, that mere heart debility is constantly interpreted as being due to the presence of fatty change in the cardiac muscle. It is occasionally a matter of surprise that a condition of extreme degeneration of the myocardium, together probably with the coronary arteries and vascular system generally, has been consistent with prolonged and even active life. At *post mortem* examinations of patients dying from causes other than heart disease it is not uncommon to find the latter organ in an advanced stage of degeneration. It seems difficult to explain the absence of heart symptoms unless it be assumed that the pericardium acts as a supporting agent holding together the weakened cardiac muscle. Scarcely enough attention would seem to have been devoted to the aid furnished by the pericardium in maintaining the integrity of a degenerate and enfeebled heart muscle. A highly instructive instance occurred in the case of a man of advanced years who died suddenly in the street. In this case most extensive fibrous degeneration of the left ventricle was present, and in one point the ventricular wall had yielded; the resulting aneurysm of the heart contained tolerably firm clot. Rupture of the aneurysm appeared to be imminent, and was apparently prevented only by firm pericardial adhesions over the site of the lesion.

There can I think be no doubt that, in not a few cases of fatty or fibroid degeneration of the heart muscle, a catastrophe is only prevented by the tightly investing and tough pericardium. The time has surely come in which the estimation of the pulse tension in accurate terms must be as necessary a part of a thorough medical examination as is the use of the stethoscope, the ophthalmoscope, or the clinical thermometer. It has been my endeavour to show how indispensable is the employment of the sphygmomanometer as a means of clinical examination, and that in a very large proportion of patients a record of pulse tension is a necessity both as regards prognosis and treatment. I feel certain that in no long time the ordinary clinical equipment will be completed by the addition of this instrument, and the result can only be in every respect thoroughly satisfactory.

PERFORATED GASTRIC AND DUODENAL ULCERS:

SOME OBSERVATIONS BASED ON A PERSONAL EXPERIENCE OF FORTY-SIX CASES OPERATED UPON.*

By ALEXANDER MILES, M.D., F.R.C.S.E.,

Lecturer on Surgery in the School of Medicine, Royal Colleges of Edinburgh; Assistant Surgeon, Edinburgh Royal Infirmary.

MR. MILES pointed out that if duodenal were included along with gastric ulcers, perforation was a comparatively frequent occurrence in males. In his series of thirty-six gastric and ten duodenal ulcers, twenty of the patients were males and twenty-six females. It followed from this that in a case of perforation the diagnosis as between appendix mischief and gastric (or duodenal) ulcer could not be allowed to depend to any extent on the patient's sex. As to the question of age in relation to prognosis, his patients had varied between 15½ and 55½ years, and an analysis of the figures showed that on the whole the prospect of recovery was better in young persons. A previous history of dyspepsia or ulcer was very common, and he had not infrequently noted that for some time before perforation occurred there had been comparative freedom from stomach symptoms. On the other hand, in not a few instances premonitory symptoms of perforation had taken place in the occurrence of exacerbations of the dyspepsia, particularly in the occurrence of pain and tenderness. Like Mr. Caird, he had been struck by the comparative rarity of a history of vomiting blood or of blood in the stools. He had analysed

(*) Paper read before the Edinburgh Medico-Chirurgical Society, July 4th, 1906.

his cases with the view of determining whether work, muscular efforts, trauma, or the ingestion of food had been the cause exciting perforation, and the general results were inconclusive; for while in one or two instances rupture of the ulcer had followed efforts, injury, strain, or a hearty meal, in most cases it was impossible to trace any definite connection between such occurrence and perforation. In eight cases the accident had taken place when the stomach was full, in thirteen, when it was partially empty, and in seven when it was presumably quite empty. The site of perforated ulcer was usually on the anterior wall near the pyloric end of the stomach, and towards the lesser curvature. Of gastric ulcers, thirty-three were anterior, three posterior; of duodenal, nine were anterior, and one posterior. In this respect his statistics corresponded pretty closely with the figures in F. Brunner's collected data. He had only one case of multiple perforation in his series. As might be expected, the largest perforations were those attended by the highest mortality. In considering the clinical features it was important to distinguish clearly between two sets of symptoms—those due to the perforation and those due to ensuing peritonitis. There was often a period of latency after the acute onset, and during this time the diagnosis was sometimes reconsidered and time lost in consequence. A knowledge of the fact that the pain, &c., which followed perforation might temporarily abate was therefore important. In these circumstances the patient and his friends might demur to the need for operation, until chance of recovery was considerably lessened. Pain, occurring suddenly, was of great diagnostic value. In two cases he had seen it referred to the back, but he had never noticed the pain under the left clavicle referred to by some authors. The seat of the pain was, in his experience, an important guide to the site of ulcer, and it was his practice to make his incision where the tenderness and pain were greatest. The pain of a perforated appendix might, however, exactly simulate that of gastric ulcer. Vomiting was not common when perforation occurred. Abdominal rigidity was extremely constant, and set in early; it was often associated with retraction of the abdomen. Percussion gave little help, and he did not place much reliance on variations in the liver dulness. After twenty-four hours it was of no assistance, either positively or negatively. Sometimes an effusion into the lesser sac gave rise to a dull area in the umbilical region; this, of course, was due to rupture of a posterior gastric ulcer. After the initial shock came a period of reaction and temporary improvement, and, for the reasons given above, it was essential to estimate this at its proper value. It was his impression that opium, besides masking the symptoms, exercised a notably unfavourable influence on the prospect of recovery.

As regards operation, he preferred a vertical incision over the most tender area, splitting the fibres of the rectus. On opening the abdomen gas and fluid escaped, but he had very seldom been able to recognise food particles in the fluid. The perforation was found by carefully removing flakes of lymph from the stomach wall. It was seldom, if ever, necessary to open the stomach in order to discover the rupture, and in general he deprecated any procedure of this kind, or gastro-enterostomy, in a patient who was collapsed from a perforation. The ulcer should be closed by a Czerny-Lembert suture and covered by an omental graft. He could not recommend that the ulcer should be excised. In some cases it might be necessary to perform pyloroplasty in order to prevent the likelihood of a future stenosis, but he did not care to perform gastro-enterostomy purely as a matter of precaution. The peritoneal cavity should be purified by irrigation, and drained by a supra-pubic tube. Local drainage he no longer employed, but raised the head of the bed so that fluid might gravitate into the pelvis. In the after treatment rectal salines and intravenous transfusion were required; he thought that it was perfectly safe to give a little fluid by the mouth after twenty-four hours had elapsed. Among the complications which had supervened in his series of cases were temporary gastric fistula, pneumonia, parotitis, phlebitis, bronchitis, and pelvic abscess. The chief factor in the prognosis is early operation; the condition of the stomach in regard to food at the time of rupture did not seem to have any influence, nor did the site of the perforation, nor the presence or absence of initial vomiting. In statistical form his results were as follows:—Operation within 12 hours of perforation: 14 recoveries, 3 deaths (26·3 per cent.); between 12 and 24 hours, 5 recoveries, 4 deaths (44·4 per cent.); between 24 and 36 hours, 3 recoveries, 3 deaths (50 per cent.); later than 36 hours, 1 recovery, 11 deaths (91·7 per cent.).

THE PROGRESS OF MEDICAL SCIENCE.

Graduation Address delivered on Tuesday, July 17th, 1906.

By JOHN GRAY M'KENDRICK, M.D., F.R.C.P., F.R.S.

Professor of Physiology in the University of Glasgow.

AFTER a few words of encouragement and advice to the graduates who were qualified and about to start in life on their varied careers in the profession, Professor M'Kendrick remarked that this address might also be considered his valedictory pronouncement before quitting the position he had held in the university for thirty years.

He then said: The next consideration I desire to lay before you is that medicine and surgery have both made remarkable progress during the last thirty years. You are all familiar with this fact. I need not enlarge on the wonderful progress made by so-called preventive medicine, by which the mortality from fevers and other infective diseases has been enormously reduced, more especially in our great towns. Nor need I do more than allude to aseptic surgery, by which thousands of lives are saved annually and the surgeon is able to perform with success many operations that were at one time deemed impossible. Gynæcology also has become a well-defined and most important branch of surgery, and by its methods lives are saved and existence to thousands made endurable. Nor can we forget that during the last thirty years the science of bacteriology has assumed such dimensions and is of such importance as to affect all departments of scientific medicine. Such progress has been made in all branches of the healing art that possibly some of you may feel discouraged, and you may think that little will be left for you to do. But you could not make a greater mistake. Marvellous

as has been the progress of the last thirty or forty years, it appears to me that we are on the road to great discoveries that may, as regards some details of practice, revolutionise the medical art.

Ideas precede discoveries in the onward march of science. The secrets of nature are not revealed at haphazard. Sometimes one with merely an inquisitive mind discovers a new phenomenon, apparently almost by chance; but the best work is done by the thinker, who meditates over phenomena with which he is familiar, and who invents a working hypothesis to explain the facts. Then he appeals to observation and experiment. The observations and experiments are then not at haphazard. The investigator knows what to look for, and he knows the kind of experiment that must be tried. Thus great general principles are established. It seems to me that we have in our day striking examples of this process of human thought. New ideas are everywhere in the air.

Physiology, pathology, and pharmacology are the hand-maidens of medicine. Practical medicine is no doubt an art, not a science, but it is based on knowledge derived from the three sciences I have mentioned. In these days it seems to me that these three branches of human activity are becoming more and more closely connected, and they are fertile in new ideas, ideas that must influence not only our conceptions of disease, but also our modes of treatment. It is now recognised that there are gradations both in health and disease. Probably a state of perfect health in any individual is rare; there are ups and downs; there are as it were different planes of health. Even in a person supposed to be in perfect health there may be morbid activity in some part of the body, some disease or other in its very earliest stages. One organ may not be performing its functions efficiently, and all the organs suffer more or less with it. It is becoming more and more clear that each organ may have more than one function, and that if one organ is the seat of disease, other organs may, within limits, act vicariously for it. We also see that morbid changes have a beginning, and if we could only detect them at this stage we might be able to employ therapeutic measures that would avert the morbid changes, or at all events modify their progress.

We also see that the body has numerous protective arrangements for defending itself against enemies, such as micro-organisms or poisonous substances generated even by itself. This is an idea only dimly perceived by our forefathers. The acidity of the gastric juice, the portal circulation, the abundance of adenoid tissue crowded with leucocytes in some of the so-called blood glands and in the alimentary tract, the influence of internal secretions, are all examples of what we may term a protective mechanism. The old physicians wrote much about a *vis medicatrix naturæ*. They had a glimmering of the truth. There is no *vis*, there is no principle that thus acts, but there is a tendency on the part of every tissue to resist attack, and if altered in a morbid direction, to revert to the condition that is normal. In your future work you will recognise these ideas, and they will help you in your practice.

It is instructive to observe how one idea leads on to another. Leucocytes were detected in the blood even by the early microscopists, but it is only in recent days that their importance has been suspected. First, their power of amœboid movement was observed, then their tendency to migrate in inflammatory conditions, and then the phenomena of phagocytosis, by which they are capable of devouring foreign micro-organisms. At the same time the life history of micro-organisms was studied. Ere long it was discovered that in many cases the micro-organism might not be injurious to the body *per se*, but that it produced a poisonous substance, a toxin. The next important step was taken when it was found that the toxin, in some mysterious way, produced an antitoxin, which neutralised the poisonous action of the toxin. This led to the formulation of the theory of Ehrlich, which has been singularly fruitful in the way of suggesting research. By the cultivation of antitoxins in serum, valuable remedial agents can now be used in the treatment of acute diseases caused primarily by micro-organisms. Nor is this the end of the wonderful story. It is found, as you are aware, that in serum there may be present bodies—chemical substances—no doubt derived from the tissues themselves, which have anti-bacterial powers. Little is yet known of the true nature of these so-called opsonins, but we have a method by which their power may be measured, and the opsonic index of the blood as a whole, or of the blood of different organs, may be determined. Here is another remarkable protective measure that may be taken advantage of in therapeutics. Whether the opsonins act by stimulating phagocytic action, or whether they so injure the infective micro-organisms as to lower their vitality, and thus make them an easy prey to the phagocytes, is not yet determined. All this has led to theories of immunisation and to measures of immunisation. It seems to me not improbable that we are entering on a new field of serum-therapeutics which may be of the greatest value. In many cases, no doubt, we will be beaten in our efforts, and the surgeon will be called in to remove, or lop off, or relieve from pressure, or give rest to ulcerated parts, but I cannot help thinking that in the future there will be less for him to do in this direction than in the past.

Another idea that is taking possession of the medical mind is that by therapeutic measures, while we cannot cure the disease, we can help the body to carry on its functions, not certainly on the high level of perfect health, but on a lower level of comparative comfort and efficiency. Physicians do not invariably attempt to treat actively a new set of symptoms that may make their appearance in a chronic case. They are afraid to do harm when they cannot see clearly that they can do good.

There is only one other idea I wish to refer to. You must have often been struck with the sad ravages of disease as revealed in the *post-mortem* room—the condition of the heart and kidneys, for example, being apparently incompatible with life. The wonder you felt was not that the patient died of the disease, but that he lived so long with organs that presented such morbid changes. When one sees a case like this, there is a tendency to be sceptical as to the use of drugs. But the condition was not of yesterday. Changes must have been going on for years, and yet the individual may have lived to a fairly old age and

even been active in the discharge of daily duty. Now, no remedies can work miracles. They cannot materially alter the condition of a diseased heart or of degenerated kidneys. And yet, if we recognise the idea that the body as a whole has wonderful compensatory arrangements and adjustments, by which life may be beneficently prolonged, we can do much by therapeutic means to assist nature. I frankly confess that as I have become older the crude scepticism of early years as to therapeutic measures has given place to a recognition of how much may be done to help by the judicious use of our *materia medica*.

It is evident, then, ladies and gentlemen, that there is still much for you to do in the active treatment of disease. Keep up your knowledge of physiology, pathology, and pharmacology. Link them together and you will find that one will illuminate and help the other. Study, for example, such a problem as that of helping a weak heart by the use of digitalis. You will find this problem full of instruction, and it will be a good test of your physiological knowledge. Do not practise by rule of thumb. Scrutinize each case that comes before you *per se*. Examinine it with the physiological and the pathological eye, and not through the distorting medium of a text-book, full of descriptions of "typical" cases. Then use your remedies wisely and well, with as full an acquaintance as you can command of their pharmacology. Take care not to do harm, and always have a definite idea as to how you hope to do good by the use of a particular remedy. This will give you satisfaction with your work.

OPERATING THEATRES.

KING'S COLLEGE HOSPITAL.

OPERATION FOR UNDESCENDED TESTICLE.—MR. BOYCE BARROW operated on a child, æt. about 5, who had been brought to the hospital on account of an undescended testicle. The testicle was lying in the left inguinal canal, where it was freely movable, but could not be protruded through the external abdominal ring. At the operation Mr. Barrow cut down on the inguinal canal which he laid freely open in the usual way; next pulling on the testicle with the fingers he opened the reflected portion of the peritoneum, and then with very great care divided the peritoneum investing the cord, which latter was made taut and brought into evidence by traction on the testicle, and thus light bands of tissue became successively recognisable. It became evident from the gradual elongation of the cord, as these bands were divided, that they constituted the chief cause of the imperfect descent of the testicle. The finger was then thrust into the scrotum and the way prepared for the testicle, which could now be carried to the bottom of the scrotum without difficulty, even to a lower level than the testicle of the right side. Its fixation in this position was effected by stitching the testicle to the subcutaneous tissue of the lower part of the scrotum, without, however, penetrating the skin (so that there should be no communication with the air in this situation). The retraction was also provided against by stitching the cord, as it passed out of the canal, to the pillars of the external abdominal ring. The inguinal canal was then perfectly closed and the wound stitched up. Mr. Barrow said that the advantages of this method were that the cord was secured in the canal by the stitches at the external abdominal ring, so that any tension on the testicle in the scrotum was obviated. He also laid stress on the importance of not penetrating the skin when stitching the testicle to the subcutaneous tissue of the lower part of the scrotum as through neglect of this precaution the air would be admitted and this would necessitate an antiseptic dressing in this position, which would tend to press the testicle upwards, whereas the object aimed at was to push the organ down by the pressure of the dressing on the inguinal canal. It was his experience, he remarked, that by the perfect division of the peritoneum the testicle could be got quite satisfactorily down in a very large number of cases, and it was, he thought, a distinct advantage for the patient not to be hampered and pained after the operation by any apparatus having for its object traction on the testicle and cord. He suggested that traction by an apparatus might possibly contribute to the atrophy of the testicle which sometimes results after the organ had been replaced in the scrotum. He considered that any necessity for an apparatus was done away with by (1) stitching the testicle to the bottom of the scrotum, and (2) stitching the cord to the pillars of the ring. He pointed out that great care has to be taken in dividing the delicate bands of tissue investing the cord, so as to avoid wounding either the vessels or the vas deferens (there was scarcely any vessel requiring ligature in the present case). The chief precaution in doing this was to carefully examine and make taut each band before dividing it. So far as his experience went in watching these cases afterwards, he said the permanent condition after this operation was satisfactory, there being but little tendency for the testicle to retract; besides, its nutrition could not be much impaired, as he had found the organ to grow fairly well after operation.

CANCER HOSPITAL.

SCIRRHUS OF BREAST.—MR. BOWREMAN JESSETT operated on a married woman, æt. 51, who had been admitted a fortnight before. She had noticed retraction of the left nipple twelve months ago. There had been no pain, but a lump had gradually developed in the breast. On admission a hard mass was found occupying the breast at the lower internal edge, the nipple was drawn in and the gland somewhat fixed to the muscle beneath. There was no ulceration of the skin. The glands in the axilla were enlarged; there was apparently no infection of the supra-clavicular glands. The patient's sister had died of cancer of the breast. Mr. Jessett removed the breast by a rectangular flap extending from the acromion process along the border of the great pectoral muscle to practically the ensiform cartilage. The flaps were reflected, the skin being carefully dissected off on either side. Next the breast was freely removed, care being taken to dissect off the fascia and integuments of the pectoral muscle. The glands in the axilla were also excised and the whole armpit cleared out, the vessels and nerves being freely exposed. It was found on deep examination that the glands were apparently affected above the clavicle, so Mr. Jessett made a rectangular flap above the clavicle and dissected down to the subclavian vessels and sheath of the carotid; he found a number of small glands which were enlarged, and these he removed. The wound was then closed without difficulty, and the patient returned to bed. Mr. Jessett said that instructions were given to tie the left arm up to the head of the bed, so as to keep the limb at right angles to the body. Mr. Jessett insisted on the importance of freely removing the fascia and integuments over the pectoralis major in all cases of scirrhus of the breast;

but he did not think it necessary to cut away the muscle itself unless the disease was found to have penetrated into its substance, as the lymphatics of the breast travel by the integuments and fascia to the axillary glands and not through the muscles. He said it was very important to examine at the time of operation the glands above the clavicle, and if they were found to be at all enlarged he considered a free dissection of the anterior triangle of the neck should be made and the glands removed, as by doing this serious trouble in the future was often averted. He pointed out the desirability after operation of tying up the patient's arm to the head of the bed so as to keep it at right angles, for by adopting this plan free motion of the limb was ensured in the future.

TRANSACTIONS OF SOCIETIES.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

LAST MEETING OF THE SESSION HELD FRIDAY, JULY 13, 1906.

Mr. PRIESTLY SMITH, F.R.C.S., President, in the Chair.

MR. A. R. BRAILEY read a paper on

CONGENITAL DISTICHIASIS.

and gave a clinical description of a case, together with the result obtained by making a microscopical examination of a small portion of the lid. The chief point of interest was the fact that the Meibomian glands were apparently completely absent, and their place was taken by hair follicles. He then gave a description of four other cases seen in the Clinic of Professor Fuchs, in Vienna. Those were the only cases seen there during a period of twenty years, and showed how rare this deformity was. He then described a case reported by Kuhnt. He drew attention to the distinction which should be recognised between trichiasis and distichiasis, and urged the advisability of limiting the latter to the congenital cases. He gave a list of other cases which had been reported.

Dr. C. H. USHER (Aberdeen) read a paper on

THE CHOROID AT THE MACULAR REGION.

He drew attention to the fact that in sections of the eyes of Albinos examined by Mr. Nettleship, and shown at a meeting of the society in November last, that pigment was present in the choroid, but limited to the yellow spot region.

He had since examined eleven normally pigmented eyes, and had found (1) a deeper pigmentation of the retinal epithelium at the yellow spot region, and an increased thickness of this layer; (2) a marked increase of the pigmentation of the choroid, and (3) an increase in the thickness of the choroid.

From the above observations it might be expected that if pigment were present at all in an Albino's eye, it would be found in the macular region.

Dr. Usher also read a paper on a case of

UNILATERAL WHITE EYELASHES AND TUFTS OF HAIR.

The patient was a girl, æt. 3, whose eyelashes on the left side were quite white, and she also had two tufts of white hair on the left side of her head. There was nothing else abnormal in the mother or child, and the pregnancy was normal in every way. The condition was first noticed about the third day after birth. All the eyelashes on the right side were light brown in colour, so also was the greater part of the hair of the head. The family history was carefully investigated, and although there were some Albinos in the family, yet no other member seems to have had this peculiar condition.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, July 15th, 1906.

PROSTATITIS IN THE MIDDLE-AGED.

WHAT is meant by prostatitis in middle life, in persons between forty and fifty years of age? How can the precocious apparition of prostatic troubles in such young men be explained, since it is generally admitted that hypertrophy of the prostate is an affection of advanced life?

The theory given by Dr. Le Fur of hypertrophy of the prostate explains the existence of the affection in middle life.

Before the French Association of Urology, that author showed that hypertrophy of the gland was only the terminal period of chronic prostatitis; intra-glandular lesions at first, then periglandular and interstitial; no foreign element was necessary to the development of the glandular lesions to give a sufficient pathogenic explanation of hypertrophy of the prostate; age only comes in as an indispensable factor, permitting the lesions of the gland to develop and establish themselves definitely. The long latent period preceding the malady is very variable; relatively short in middle life, it lasts generally much longer in other cases, when the symptoms begin to appear between sixty to seventy years of age.

This conception of the inflammatory nature of hypertrophy of the prostate had already been entertained by a certain number of authors as Griffiths, Reliquet, Guépin, &c., who believed that this affection was a frequent consequence of gonorrhœal prostatitis. However, a large number of patients suffering from hypertrophy of the prostates had never contracted gonorrhœa.

According to Le Fur, hypertrophy of the prostate can result from all inflammations of the gland, due to a general affection, infectious malady or an intestinal affection, especially to muco-membranous entero-colitis.

Hypertrophy of the gland can be also produced by simple modification or troubles of the secretion or excretion of the prostatic glands. It was to this hypersecretion, hyposecretion, or retention of the products of secretion, that Le Fur gave the term of aseptic prostatitis or prostatitis of physiological order. As these cases arise chiefly from sexual abuse (prolonged, modified or too frequent coitus and masturbation).

In middle life the lesion of the prostate differs from those observed at a much later period. Instead of the hard sclerous form, a gland, soft and vascular, with hypersecretive and notable hypertrophy. It is this variety that is the most amenable to treatment.

One or two cases in point: Patient, æt. 40, had several times gonorrhœa with symptoms of subacute prostatitis, frequent attacks of congestion, during which the patient did not wholly empty his bladder. Prostate soft, large, double-lobed.

Massage of the prostate produced an abundant flow of prostatic liquid and milky urine. The massage was continued and the urethra was largely dilated, while a solution of nitrate of silver was instilled into the posterior urethra.

At the end of a month the patient was able to empty his bladder completely, and the cure was complete.

Another patient, æt. 38, had several times gonorrhœa. suffered from nocturnal incontinence, constipation. Prostate large and soft. After two months' treatment as in the first case the patient was definitely cured.

From the above it is evident that the best treatment in prostatic affections of middle life consists in massage, large dilatation of the urethra, instillation and irrigation of the canal.

GERMANY.

Berlin, July 15th, 1906.

AT the Medical Society, Hr. Wolff related the following case: A woman who had aborted four times in three years, found herself pregnant again, and again aborted. The speaker found in the outer wall of the cervix uteri two sharp points and discovered that they were the two tips of a hair-pin. He managed to extract them after cutting off the points. The patient confessed that she had introduced a hair-pin with the convex end foremost, into the cervical canal for the purpose of procuring an abortion. She made a good recovery.

Hr. Hirschberg advocated the use of the magnet for extraction of the hair-pin in similar cases.

Hr. Oppenheim reported

TWO SUCCESSFUL OPERATIONS FOR TUMOUR OF THE SPINAL CORD.

The cases showed the great value from the point of view of treatment of the exact localisation of tumours. The first case was that of a woman, æt. 33 when first seen, who in November, 1904, came to the poliklinik complaining of pain between the shoulders and the neck. In October there had been pain and a feeling of weakness in the left arm. Examination showed narrowing of the left pupil, some paresis of the left upper extremity, especially weakness of the biceps and the muscles of the hands and fingers. Slight diminution of electrical excitability, paræsthesia in the arm, and deadening of sensibility; the left leg dragged on walking with slight spastic paresis, no atrophy or vasomotor disturbance. There was no evidence of syphilis. On the right, sensibility was markedly diminished as far as the second rib. The course of the disease pointed to a new growth at the level of the sixth and seventh cervical vertebræ of meningeal origin. There was also tenderness on pressure.

The patient was sent to the surgical klinik for operation. The Rontgen rays showed no changes. The patient could not bring herself to decide for an operation and left the hospital.

In September she returned, as the condition had got very much worse. There was now complete paralysis of the lower extremities, especially pronounced on the left side, great reflex irritability, and spastic phenomena on the right; there was also paralysis of the sphincters. The compression of the spinal cord had become complete. The pain, moreover, had now ceased, a symptom not rarely observed in this disease.

The operation was performed on September 23rd by Burckhardt. The tumour was found in the exact situation predicted and removed; it was intradural, and was reached after removing the sixth and seventh vertebral arches. The cord was compressed almost to a ribbon at the site of the tumour. It was a fibro-sarcoma. Improvement soon took place. In four days slight movement returned in the legs. Early in October, the sphincter function returned. Some attempts were made at walking. The patient now walked quite well; only slight traces of Brown-Séquard's paralysis remained. The right arm acted quite well; the muscles of the left were atrophic.

The second case was that of a man, æt. 49, who came to the poliklinik in July, 1905. He first had signs of paræsthesia in the legs in the autumn of 1904; then pain followed in the back and abdomen, and, after that, weakness and stiffness in the legs, weakness of the bladder, and impotence. On admission, there were found to be weakness in the legs with stiffness of the muscles and exaggeration of the knee-jerks. Ataxic movements on both sides, disturbance of sensibility, and particularly of the sense of temperature, which on the right side from the umbilicus to the seventh rib was quite extinguished, whilst the symptom was less pronounced on the left. On movement, there was pain in the middle of the dorsal region; here there was also tenderness on pressure over the fifth dorsal vertebra. The diagnosis lay between a new growth in the cord or paralysis of the lateral columns. The speaker could not, therefore, advise operation, but first of all treatment by massage, &c. At first there was improvement, but it did not continue; the disturbance of movement and sensibility rather increased, so that the speaker felt certain the case was one of new growth. An operation was performed by Burckhardt on March 22nd. The tumour was found at the expected spot; but for its extirpation three arches had to be removed. It was a fibro-sarcoma. It could only be removed piecemeal through being so crumbly. Improvement was noticed even on the second day; then, however, a short period of exacerbation took place with rise of temperature and incontinence. After six days, however, steady improvement set in. At present the most noticeable feature was some ataxic movement. It was hoped that as the operation was so recent (two months) the remaining signs of paralysis would also disappear.

AUSTRIA.

Vienna, July 15th, 1906.

SPINAL NEOPLASM.

AT the Gesellschaft Schreiber exhibited a patient whom he had previously shown to the Society two years ago. According to the history of the patient the illness commenced about Christmas, 1902, with great pain in the left shoulder, which was treated for weeks as rheumatism. In February, 1903, or two months later, the lower part of the cervical vertebræ became very tender, and the neck began to increase in thickness. Movement gave great pain and the suffering still increased with neuralgic severity till head and arm could not be moved. A surgeon was consulted and spondylitis diagnosed. Shortly afterwards a large fluctuating tumour appeared. Morphia and other sedatives were given to alleviate pain. Paræsthesia began to appear in the left arm, which soon developed in tonic spasms of the whole body, permanent paresis and atrophy of the left arm. These paralytic conditions increased till the left leg was similarly implicated. This went on increasing till the neck measured 44 centimetres in June, although it was only 36 centimetres in February, two months after the disease commenced. The patient was taken into Schnitzler's clinic where she lay four weeks, awaiting a favourable opportunity for operation, as the diagnosis was now confirmed that a neoplasm was present. During this delay the tumour took on a hardening appearance and soon became as hard as bone. In the autumn of 1903 the neuralgic pains subsided, the tumour became less in size and the patient began to move about greatly improved in general strength, and nervous system normal. The case was presented at a meeting two years ago, May, 1904, with a Röntgen photograph. On the posterior surface of the lower cervical vertebræ a large bony tumour about the size of a man's fist with its base lying on the spinous process and arch of the vertebræ while the canal and body were perfectly free. The tumour seemed to contain within itself portions of bony structure enclosed in capsules.

The tumour was allowed to remain undisturbed without therapy or operation of any kind whatever, as the health seemed good and all danger of paralysis had disappeared; while the circumference of the neck descended from 44 centimetres to 37·8. The last Röntgen examination was made in April of present year, when nothing but the capsule of the tumour seemed to be left. After four years' observation with very little treatment we are able to declare the tumour neither caries nor malignant, and only a mixture of fibrous and cellular tissue with calcareous deposit.

ANEURYSM.

Frisch showed a preparation taken from the ulnar artery of a patient he showed to the Society on April 27th, when a little discussion arose on the propriety of extirpating the tumour as the man was æt. 64, and the diagnosis sclerosis.

Notwithstanding the division of opinion Frisch operated, and has proved to his opponents that no arterial sclerosis exists and that the cause of the

aneurysm is what he affirmed from the first, to repeated or chronic series of injuries to the artery.

SEMMELWEIS MEMORIAL.

An appeal is now made to the Vienna practitioners to subscribe to the erection of a statue to the memory of one who has done so much for medicine and mankind. He is represented as preceding Lister in antiseptics and particularly demonstrating the etiology and prophylaxis of child-bed fevers. There is a statue of Semmelweis at Buda Pest already, but Vienna thinks it a duty to erect another in the town in which he laboured.

HOSPITAL ACCOMMODATION.

Vogler made an interpellation in the House of Parliament on the want of accommodation existing in Vienna at the present time for infectious diseases.

The case of a labourer was given who went round all the Vienna hospitals seeking for admission, but was refused. At last he resolved on theft to force his admission, and stole a pair of boots from a shop window. He was apprehended and secured his object. On recovering from the disease he was again taken before the justices and punished with three days' imprisonment. The case is causing a good deal of public and private incrimination.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

NOTIFICATION OF INFECTIOUS DISEASES IN EDINBURGH.—For many years after the adoption of a system of notifying infectious diseases in Edinburgh, measles was included among the diseases notifiable. About four years ago, however, on the adoption of the General Act, instead of the private Act previously in force, notification of measles was dropped. The Public Health Committee of the Town Council have recently, by a majority, carried a resolution that the first case of measles occurring in a family should be made notifiable, and the proposal will come before the Town Council at an early date. Councillor Robertson, who is a medical man in active practice, has also moved that the notification of phthisis be made compulsory. This resolution has been remitted to a sub-committee for consideration and report. The notification of measles was suspended because it was found, as in other towns, that it had no effect in checking epidemics. The object of notifying first cases seems chiefly to be that it will allow the authorities to discover when the disease is prevalent, and guide them in taking general measures to check its spread. From the nature of the infection there is, of course, no hope that isolation of individual cases, once the disease has declared itself, can prevent extension of infection to anything like the same extent as in the case of most other diseases.

BALDORAN ASYLUM FOR IMBECILE CHILDREN.—The directors have marked the completion of the fiftieth year of the existence of this institution by issuing a review of the rise and growth of the asylum. The original building was designed both for imbeciles and orphans, the idea being that when the former reached a certain stage of cure association with normal children would be beneficial. In the light of present knowledge it is no surprise to learn that this idea was not justified by events, it being found that the imbecile exercised a deleterious influence on the normal children. At the time of its opening in 1855, the asylum received patients under a sheriff's warrant as in the case of adult lunatics. Now, of course, this clumsy procedure has passed away, and private pupils are admitted as their guardians desire as easily as any children can be sent to any educational institution. In 1855 there were 5 girls and 2 boys resident, and the work of the institution fairly commenced. In 1858 the asylum came under the newly created Lunacy Board, and among other results was that more attention began to be paid to physical improvement and less to ordinary teaching. This year closed with 17 pupils, the numbers seeking enrolment on the books of the institution, until in 1879, when the buildings were greatly extended, the licence was increased to 70 pupils, and this year, with additional new buildings the institution is licensed for 160 children, of whom already 154 are resident. In the half century of its existence 676 children have passed through the institution, and it was never so full as now. In the concluding pages of the report, Dr. Greig, the medical superintendent, describes the present work of the asylum. Those who take an interest in the question of the education of the feeble minded will find in the Baldoran Jubilee Report much that is suggestive.

EDINBURGH ROYAL INFIRMARY.—At their last meeting the managers appointed Dr. R. W. Philip, one of the ordinary physicians, vice Dr. Smart, whose tenure of office will shortly expire; Dr. Norman Walker was also appointed physician for diseases of the skin, in place of Dr. W. Allan Jamieson. The managers have decided to decline the offer of the Admiralty to give them the use of the Royal Navy sick quarters at Butlaw as a sanatorium. The buildings are some distance from the railway station and are considered otherwise as unsuitable.

LETTERS TO THE EDITOR.

THE CHRISTIAN SCIENCE TRIAL.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Mr. Clement H. Sers is quite correct in the suggestion in the last paragraph of his excellent letter in your issue of July 11th; but as much confusion seems to prevail as to the law of responsibility in the case of such sects as the Peculiar People and Christian Scientists, perhaps you will allow me to state broadly how the matter stands. Parents and guardians having charge of children are bound to obtain medical aid when called for. If they fail in this duty, and if it be proved that death is accelerated or caused by their neglect, they are liable to a charge of manslaughter. In all such cases a coroner would so instruct his jury. Persons in charge of adults not able to look after themselves—for example, idiots, imbeciles, or lunatics—would, under similar circumstances, have the same responsibilities. In the case of other adults there exists, of course, no law to compel anyone to avail himself of medical science or to call in a medical man; and there is no legal obligation upon friends or relations or attendants to insist upon the summoning of medical aid. The recent Christian Science case was complicated by the fact that one of the attendants was a qualified medical man. His own evidence, and much corroborative evidence, however, went to show that he had given up medical science in favour of Christian Science; that he was called in by the deceased man expressly because he was a Christian Scientist; and that it was thoroughly understood and agreed upon between them, that the case was to be treated not according to medical science, but according to the ritual or rites of the religious sect in question. Although such a course might seem to differ in some cases very little from deliberate suicide, there appears nothing in the law to make anyone concerned liable to a criminal charge. The Judge at the late trial clearly laid this down. The same judge had within the previous few weeks passed a sentence of hard labour upon a member of the Peculiar People—a father whose children had died through lack of medical treatment—and there can be no doubt the Judge, one of the hardest-headed on the Bench, was fully master of the law which he was called upon to interpret.

I am, Sir, yours truly,

July 11th, 1906. COMMON LAW.

"SHODDY LEARNED TITLES" AND THE "VALUE OF AMBULANCE WORK."

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—My attention has been drawn to your leaderettes in your issues of June 27th last, *re* "Shoddy Learned Titles" and "Value of Ambulance Work."

Apparently you are not aware of the full facts of the case, inasmuch as a local practitioner wrote some "Notes on First Aid," and on the front appeared his name followed by his medical titles, L.R.C.P., L.R.C.S. L.F.P.S., and then followed certain Indian appointments, and then in capital letters, M.B.,M.A., F.R.G.S. This constitutes the basis of the complaint of the local medical men in this city, which led to the case being laid before the branch of the B. M. Association. As your leaderette shows such an interest in the matter, I have pleasure in informing you of the above points.

I am, Sir, yours truly,

ETHICS.

Bradford, July 13th, 1906.

THE NEWSPAPER PRESS AND QUACKERY.

WE are allowed to print the following excerpts from a private letter from a distinguished F.R.S., and Professor in the Biological Department of one of our English Universities :—

"I was very much interested in your articles on the subject of quackery, and I quite agree with your views on that subject, and also on the painful degeneration of the *Times*. I think the *Times* has not nearly so much influence now as it had formerly. In the North, very few people seem to read it or pay attention to its opinions. . . . The great mischief and injury done by quackery, however, chiefly affect people who never see the *Times*—I mean the lower middle and working classes. We have hundreds of quacks in —— doing a thriving business, and inflicting untold misery on the people of these classes. These people have much more faith in advertisements than in leading articles. I believe that the only thing to advocate is much more stringent legislation. It ought to be a penal offence for an unqualified man to advertise for patients suffering from consumption, cancer, &c. By co-operation with workers among the poor, a great deal of startling evidence could be found concerning the injuries inflicted by quacks. . . . I think that the best, if not the only opportunity that the medical profession has of appealing to the intelligence of the layman is that afforded by the October addresses at the medical schools, which are widely read by the general public. How rarely do they deal with the subject of quackery."

SPECIAL ARTICLES.

THE NEW PRESIDENT OF THE ROYAL COLLEGE OF SURGEONS, ENGLAND.

MR. HENRY MORRIS, Consulting Surgeon to the Middlesex Hospital, has been elected by the Council, the president of the Royal College of Surgeons for the ensuing year. We congratulate Mr. Morris upon the high honour to which he has attained. Everyone will admit that he is a distinguished representative of the art of surgery in this country, and in gaining that which no doubt has been his ambition, we are sure that Mr. Morris will worthily fulfil the duties of the post, and amply justify the confidence which has been placed in him by his colleagues. Mr. Morris has worked well and laboriously for the college in the past as chairman of the Finance Committee of the Council, his elevation, therefore, to the presidency has doubtless come partly out of regard for his previous services, and in recognition of his fitness for the post. There is no gainsaying the fact that a man of good business parts is a *sine qua non* for the presidency of the college.

By virtue of his office he is frequently called upon to represent the college at public functions, social and otherwise, and it goes without saying that a good deal is always expected of him who has been adorned with the Blue Riband of surgical science in this country. There is, however, another aspect of the Presidential office which, it appears to us, claims somewhat serious attention, and that is the absence of any regular method on the part of the college of returning the hospitality which it receives through its representative. The president, by virtue of his office, is frequently invited to attend public dinners; that is to say, the college is entertained through its president, but the president cannot officially reciprocate the hospitality which he receives. A new order of things might, with advantage be inaugurated in this regard, and the council might arrange to give two, or perhaps, three, annual dinners to which might be invited the leading men of the sister professions and others from whom the college had received hospitality. In following out this suggestion the Council would be doing nothing more than that which has been the rule adopted by the Benchers of the various Inns of Court. However, it might be argued that the College of Surgeons is not a social club, but an institution devoted to science. That, of course, must be admitted; nevertheless the point must also be conceded that not even a scientific institution constituted as the College of Surgeons is can really afford to ignore the amenities of social life as existent in the present day. We believe that it would be to the interests of the College generally, and to the advancement of the surgical profession, were the policy to be inaugurated to which attention is here drawn.

SIR CHRISTOPHER NIXON, BART., M.D., F.R.C.P.I.

Physician to the Mater Misericordiæ Hospital, Dublin.

WE have already referred to the honour conferred on Sir Christopher Nixon, and through him to the medical profession in Ireland, by the awarding to him of a Baronetcy on the recent occasion of the celebration of his Majesty's birthday. Sir Christopher has also been honoured by being the recipient of the Honorary Diploma of L.A.H. from the Apothecaries' Company of Ireland. On this occasion, the Deputy Governor of the Hall, who introduced Sir Christopher, said he has filled every position to which his colleagues could elect him. He is Dean of the Medical School of the Catholic University—the most flourishing, indeed, we believe that we are correct in saying that it holds the unique position of being the only Medical School in Ireland which has an ever-increasing number of students passing through its portals. How much the remarkable success of this school is due to its Dean can be imagined. Sir Christopher Nixon is also a past

President of the Royal College of Physicians, and he still represents the Royal University of Ireland on the General Medical Council, the supreme governing body of our profession. He is Senior Physician in the Mater Misericordiæ Hospital, where his cliniques have always been of surpassing success and popularity. Her Majesty, our late beloved and ever-regretted Queen, was pleased to create him a Knight Bachelor, and to-day all English-speaking people read of the distinction conferred upon him by our gracious Sovereign King Edward VII. This honour can scarcely be more pleasing to its recipient than it is delightful to the medical profession in Ireland.

REVIEWS OF BOOKS.

HAIG ON THE URIC ACID PROBLEM (*a*).

JUDGING from the rapidity with which new editions of Dr. Haig's works issue from the Press, his now well-known views in relation to uric acid must have many followers both in the profession and amongst the general public. It is to the public that the present volume is addressed, and it says much for the decadence of the race that it should be necessary to issue a second edition within two years of the appearance of the first. Not that we wish by the use of the word decadence to cast any slur on the book or on the theories that it embodies, but to comment on the fact that so many of the general public are such close students of their often trivial symptoms as to be ready to procure, and we presume read, and possibly even follow the advice contained within it.

The last edition of Dr. Haig's larger work on the same subject received a lengthy review in our columns some two years ago. In it we dealt in some detail with his theories, and so it is unnecessary to repeat the opinions therein expressed, opinions we may say which have undergone no change since then. We need. therefore, only again point out that one of his fundamental assumptions, namely; that uric acid is always manufactured in the body in a definite proportion to the amount of urea manufactured, is untrue, and that in accordance therewith much of his argument at once falls to the ground. We may also say that Dr. Haig argues too much from the particular to the general, and that although some individuals possibly exist who, constituted like himself, find it desirable to restrict their diet to milk and cheese, it is absurd to argue therefrom that the whole human race, the majority of which happily is in excellent health, should do likewise. Even the possibility of extending one's life beyond the usual span, and prolonging one's days as an emaciated hypochondriac to a hundred years or more would, we are glad to think, hardly be a sufficient inducement to the average individual to make him sacrifice his briefer and happier life and more virile diet for the food of a confirmed invalid. An individual who feels ill if he eats an ordinary meal is obviously an invalid, and to such Dr. Haig should address himself and not to the world in general. Perhaps, indeed, we should be far more moral if we followed his precepts, but the extra morality would be bought with the loss of our position as a nation, and in these days when underfeeding and physical degeneration are regarded as so closely allied, we feel indeed that Dr. Haig must be courageous to so insist upon his views.

While making the above criticisms, we must in fairness add that the book itself is fascinating, and we can well understand how convincing it must appear to the uninformed, uncritical and neurasthenic layman. Perhaps its fascination suggests the advertisements we are so familiar with and which are worded so as to include all symptoms as the ones the remedy vaunted is beneficial for, or possibly it lies in the evident conviction of the author of the truth of his statements. The latter possibility we believe to be the true one, and while disagreeing with the author, we must at the same time congratulate him on the way in which he defends and maintains his opinions.

(*a*) "Uric Acid. An Epitome of the Subject." By Alexander Haig, F.R.C.P., Physician to the Metropolitan Hospital. Second Edition. London: J. and A. Churchill. 1906.

SHAW-MACKENZIE ON THE TREATMENT OF CANCER. (*a*)

THE fact that this work should have quickly passed into a third edition is sufficient testimony to the value of the facts and conclusions brought forward by the author. There is a charm, as well as an attraction, about this book, inasmuch as it deals with many hitherto but little-known physiological processes and applies them to clinical investigation. Thus it opens up a new field of science, apart from the special subject with which it deals, and within a small compass brings many an interesting fact before the general reader, which, under ordinary circumstances, he would never be likely to come across. How many practising physicians and surgeons, for example, ever heard of trypsin before the author brought it under the notice of the profession and proved its therapeutic value, besides showing its action upon glycosen. Furthermore, in this new edition, we are introduced to another animal ferment named Crepsin, the universal presence of which in animal tissue has been proved by the researches of Dr. H. M. Vernon. Cohnheim was the first to discover it, and the author draws attention to its probable value, in the treatment of cancer, as an adjunct to trypsin, inasmuch as experimental inquiry has demonstrated that the succus entericus, "crepsin," acts as a stimulant upon the pancreatic function, and so aids in the secretion of the proteolytic ferment of the pancreas. Here, then, is another problem which the work of the author has presented to the profession, namely, to what degree does the action of crepsin control or modify the cell growth in cancer when administered in combination with trypsin, and whether it has any influence in rendering the action of trypsin more effectual in such cases. Time only, and repeated observation can, of course, determine this point; meanwhile, it is just possible that trypsin alone may be indicated in some cases, and crepsin alone in others, in order to obtain the best results by this treatment. Thus it must be evident that only those who especially lay themselves out carefully to study the problems of this new therapeutic application of the animal ferments to the treatment of cancer, as laid down by the author, can hope to realise the expectations which he foreshadows as possible. Rome, as we are accustomed to be told, was not built in a day, neither can the exceedingly complex problem of the therapeutical treatment of malignant disease, be conceived, elaborated and perfected within the short compass of, say, a few months; and yet the results so far of the trypsin treatment, in this regard, have, as proved by the author, been so uniformly encouraging as to raise the best hopes that the arrest and cure of cancer is now within a measurable distance of accomplishment. We have, therefore, every confidence in highly recommending this work to the profession and urging its careful perusal.

LUNN'S PHILOSOPHY OF VOICE. (*b*)

THE success which this work has already attained has induced the author to revise it and to add much entirely new matter. The writer has gone to the song-birds for his fundamental teaching, as they give us correct examples of voice production from which we can learn much. In considering the infant voice the author points out that at the first cry of life we have clearness, volume, and intensity, three fundamental elements, and only continuity is wanting to transform such cry into musical sound. He warns

(*a*) "The Nature and Treatment of Cancer." By John A. Shaw-Mackenzie, M.D. Lond. Third Edition. Revised and Enlarged. London. Bailliere, Tindall and Cox. 1906. Price 2s 6d.

(*b*) "The Philosophy of Voice, showing the Right and Wrong Action of Voice in Speech and Song, with Laws for Self-Culture." By Charles Lunn. Pp. xix., 257. With 26 Illustrations. Tenth (Standard) Edition. Demy 8vo, 6s. net. London: Bailliere, Tindall and Cox.

against clavicular and so-called abdominal breathing. While singing we must never breathe through the nose. Singing under nasal inspiration is, he maintains, a physical impossibility. The chapter on the Natural Physics of Voice is excellent. Lunn maintains that it is a mistake to allow the singing voice to rest between the period of youth and adolescence. The break at puberty is only Nature taking advantage of a quickened growth of the parts to try and assert her original conditions from which she has been made to stray by speech and by vocal tuition.

The whole object of the work before us is to show the importance of keeping close to Nature. He harks back to the old school, and shows by examples that the compass of the bye-gone musical voice was greater than that of present day singers. This was owing to the better teaching and voice-production in these days. A chapter is devoted to stammering, which the author defines as a stoppage that cannot be moved. The mode of treatment suggested is based on sound principles, and is well worthy of consideration and trial. Looking at the book as a whole we are bound to admit that its teaching is sound. The subject is handled in a novel and fascinating manner, and the book differs very materially from all others of its class. It practically stands alone as the best treatise on voice production in the English language. There is not a dull page in the whole work, and it may be safely recommended to singers and public speakers as a trustworthy guide. Medical men will find much of interest within its pages, as patients often suffer from affections of the voice which cannot possibly be treated correctly, unless we have some general principles to guide us. The book is well printed, and tastefully bound and contains a number of beautiful illustrations. We warmly recommend it to those of our readers who may be interested in this important subject.

CARSON'S SURGICAL DIAGNOSIS. (*a*)

AFTER careful perusal we have come to the conclusion that this represents one of the best of a popular series of small books. Its 140 pages cover a great amount of ground, and cover the chief points of diagnosis in all the more important surgical conditions. Under the heading "Appendicitis," for instance, the main features that have to be weighed by the medical attendant are marshalled in a condensed analysis that is likely to be most useful to the student preparing for examination, or the busy practitioner wishing to refresh his memory upon the salient facts of the malady. What is said of appendicitis applies to the rest of the subjects treated by the author. We have also an excellent bird's-eye analysis of abscess of the liver, and the author has exercised the greatest care and judgment in every page of this little book, from the first chapter on "Methods of Examination," to the last on "Surgical Diseases of the Respiratory Organs," surprise being uppermost in the reviewer's mind after careful perusal, that it has been found possible to condense so much sound knowledge into such small compass.

COLBECK AND CHAPLIN'S PRESCRIBING. (*b*)

THIS is the second, enlarged and revised edition of a well-known and already much appreciated work. The subject is one of very great importance, especially in these days when we fear prescription writing is becoming a lost art. With this book before him, no student or practitioner need experience any difficulty in framing prescriptions for himself. The authors have made everything as simple as words can do, and have spared no pains in bringing home to their readers the importance of the subject from the point of view of everyday practice. The subject is treated largely from the clinical standpoint, and special attention has been directed to the means for correcting and disguising the taste of nauseous drugs. The various systems are dealt with *seriatim*, and prescriptions suited to the diseases of these systems are suggested and worked out in detail. This is a thoroughly practical guide, and no physician can afford to be without it unless he happens to be one of the old school. The profession owe a debt of gratitude to the authors of this valuable work for the pains they have taken to lay a sound foundation for the art of prescription writing which ought to be more generally practised by medical men. This volume has evidently a great future before it, and at present it certainly holds the field in its own particular subject.

BODILY DEFORMITIES. (*a*)

ON the death of the author of these lectures, Mr. Poland was requested to edit and revise the first volume. He has not attempted to alter the lectures from their characteristic style, but has merely omitted several obsolete tables and notes. The lectures—six in all—deal mainly with the etiological factors involved in the production of deformities of the human skeleton. These deformities the late Mr. Chance had exceptional opportunities of studying. In the lecture on "The Causes of Deformities Acting on the Embryo," the author has a good deal to say on the subject of maternal impressions, and cites a number of interesting examples. He is, however, a sceptic and entirely disbelieves in the asserted potency of such influences. He maintains that the parent can neither add to nor diminish the power of development which exists in the ovum immediately after impregnation, whereas there is no proof when once development has commenced the embryo is placed completely out of the mental influence of the parent.

In one of the lectures the author considers rachitis and scrofula as causes leading to acquired deformities. It is interesting to read that he regards all cases of rachitis as originating during uterine life—*i.e.*, "while development is going on, and while the basis of the osseous tissue is being laid down, and its constitution, as it were, given to it." He is, moreover, assured that this is a disease which is "unquestionably hereditary. The disease may remain dormant for a short time after birth, but as soon as the mother's milk is withdrawn then the disease resumes its activity and asserts, its powerful influence upon the skeleton generally, in the tissues of which the germ had been already implanted during uterine life." This view of rachitis is one which the author supports by table and data, but he overlooks entirely the effects which the disease has upon the tissues generally. His opinions, however, are interesting when considered in the light of more modern and advanced pædiatric knowledge.

Considering that fifty years have passed since these lectures were first delivered, we cannot wonder that much advance has been made in orthopædics; but still, nevertheless, Mr. Chance's observations remain to-day what they were then—a sound basis on which to rear a true physiological knowledge of this important branch of surgery. The present editor has endeavoured to embody in the form of very copious footnotes recent material bearing on the subjects under consideration, and he has added very considerably to the author's original drawings and notes of cases by others of his own. Mr. Poland hopes that these pages may afford some new material for reflection, and in this expectation we feel sure he will not be disappointed. We shall look forward with interest to the second volume, which we

(*a*) "Aids to Surgical Diagnosis." By H. W. Carson. F.R.C.S., Surgeon, Tottenham Hospital. London: Bailliere, Tindall and Cox, 1906. Price 3s. 6d.

(*b*) "The Science and Art of Prescribing." By E. H. Colbeck, B.A. M.D.Cantab., F.R.C.P., B.P.H.Camb., Physician to the City of London Hospital for Diseases of the Chest, &c., and Arnold Chaplin, M.A., M.D.Cantab. F.R.C.P., Physician to the City of London Hospital for Diseases of the Chest, &c. Second Edition. 3s. 6d. net. London: Henry Kimpton.

(*a*) "On the Nature, Causes, Variety and Treatment of Bodily Deformities: In a Series of Lectures." Delivered at the City Orthopædic Hospital in the year 1852, and subsequently, by the late E. J. Chance, F.R.C.S., Surgeon to the City Orthopædic Hospital, &c. Edited by John Poland, F.R.C.S. Surgeon to the City Orthopædic Hospital, &c. Second Edition. In two volumes. Vol. I., 6s. net. London: Smith, Elder & Co.

trust will soon make its appearance. Meantime, the editor must feel considerable satisfaction on the issue of this work and the completion of part, at least, of what to him has been all through a labour involving no little time and trouble.

HEWLETT'S PATHOLOGY. (a)

This book is a good type of the modern school of pathology, which keeps in view the practical ends of its special branch of study. It does not profess to cover the whole field of knowledge, as known to the expert, but deals with the essentials of general and special pathology, such as are required by the medical student. The author in this way attempts a difficult task, which on the whole he has performed successfully within the compass of 525 pages of crown octavo size. The plan of the book renders it a convenient work of reference for the busy general practitioner. For instance, if he turns to any special point, such as malaria, gout, syphilis, or glanders, he will find all the salient points briefly noted. Of the *Spirochæta pallida*, it says that long spiral organisms of that organism have recently been detected in the lesions of syphilis, but that the specific micro-organism is unknown. A beautifully clear and concise account is given of the special pathology of the pancreas, an organ to which much attention has been devoted of late years. Although the condensation of the subject matter in this book has been insisted upon, it should be clearly understood that it is in no sense a cram book. An immense amount of special knowledge is presented by the author, who from his long experience as a lecturer at King's College, London, knows exactly what points the student should consider with the best advantage to himself. The book is certain to become popular among medical students, as in many ways it presents an ideal plan of conveying information useful for examinations.

GUIDE TO FINGER-PRINT IDENTIFICATION. (b)

THE recently-perfected method of identification by finger-prints is fascinating, if of no particular import to medical men. Its simplicity and its apparent trustworthiness combine to confer upon it a quite exceptional value in establishing unknown or contested identity. We are all branded by nature with an indelible and distinctively individual tracing which he who runs may read. The time may come when friends will exchange finger-prints as they now exchange photographs. A piquant interest is given to the subject by the photographic reproduction of finger-prints that have actually served to identify the criminal in a celebrated murder case.

The author claims to have been the first to call public attention to the method (*Nature*, October, 1880), and he is evidently very jealous lest the credit for having thought it out and introduced it should be wrested from him. This is, of course, very legitimate, but having formally registered his claim, he might well dispense with the elaborate documentary arguments which he brings to bear.

Mr. Faulds explains to us how the prints are obtained, how they should be dealt with for purposes of examination and classification, how they are generically classified, and the relative identificative importance of the special points observed; in short, with this book in hand and the disposition to work out the subject, every reader has it in his power to become an expert finger-print reader. To confer a medical interest on the subject, it remains to demonstrate that certain "whorls" "loops" and combinations thereof possess, at any rate, a pathological bearing. We should not be surprised to find that certain patterns are peculiar to light and dark-haired people respectively, that their diameter corresponds to height, or size of mouth, and that a measure of obliteration suffices to establish approximately the age of the "subject." It is obvious that this line of investigation is only in its infancy, and if clever women can base a forecast of our fate on a careful inspection of the comparatively coarse features of the palm, what may we not hope for from scientific study of the infinitely more delicate and complicated marking of finger-tips? *Verb. sap.*

(a) "Pathology, General and Special." By R. Tanner Hewlett, M.D., M.R.C.P., D.P.H., Professor General Pathology, &c., at King's College, London, &c. London: J. and H. Churchill, 1906. Price 10s. 6d. net.

(b) "Guide to Finger-print Identification." By Henry Faulds, L.F.P.S., late Surgeon-Superintendent of the Tsukiji, Tokyo. Hanley: Wood, Mitchell and Co., Ltd. 1905. Price 5s. net.

OBITUARY.

JOHN HENRY EDDOWES, J.P., M.D., M.R.C.S., OF LOUGHBOROUGH.

THE death occurred on the 11th instant of Dr. John Henry Eddowes, J.P., at Loughborough. In the neighbourhood the deceased was one of the most popular of medical gentlemen. He was born at Loughborough, on October 13th, 1823, and was the son of the late Mr. John Henry Eddowes, surgeon. He was educated at the Loughborough Grammar School, and after one year at the Nottingham Hospital he went to St. Thomas's Hospital, London. In 1843, Mr. Eddowes obtained a prize for comparative anatomy; the following year he won the Chiseldon silver medal for clinical medical reports; and the following year secured the prize for clinical medicine. He became M.R.C.S. in 1846, and the same year L.S.A. In 1850 he took his degree of M.D., with honours at the University of Glasgow. In 1847 he joined his father in practice, and was later appointed honorary surgeon of the Loughborough Hospital.

Society for Relief of Widows and Orphans of Medical Men.

AT the Quarterly Court of the directors of this Society, held on Wednesday, last, July 11th, Dr. Blandford, President, in the chair, fourteen members were present. The death of Dr. John Clarke was reported, who was elected a member in 1847, and had been one of the vice-presidents since 1867. Four new members were elected. The sum of £1,358 10s. was voted for the half-yearly grants to the annuitants of the charity. Five letters had been received from widows of medical men since the last Court, asking for relief, and this had in each instance to be refused, owing to the fact that their husbands had not been members of the Society. Mr. Edward J. Blackett was re-elected secretary. The membership of the Society is open to any registered man, who at the time of his election is in practice within a radius of twenty miles from Charing Cross. Full particulars and application forms may be had from the Secretary at 11, Chandos Street, Cavendish Square, W. The next election is on October 10th, and names of intending candidates must be received on or before September 19.

The Caledonian Medical Society.

AT the twenty-sixth annual meeting of this Society, held last week at Stirling, under the presidency of Dr. W. A. Mackintosh, of Stirling, the report by the hon. secretary showed the membership to be 232, or double what it was ten years ago. Financially also the society was in a stronger position than ever it had been. Dr. A. Little, of Bradford, was appointed president for the ensuing year, and Dr. J. Keay, of Edinburgh, vice-president. Dr. John Dunlop, Bradford, and Dr. Cameron Blair, of Northern Nigeria, were elected to vacancies on the council. It was resolved to hold the next annual meeting in Bradford. Dr. Mackintosh then delivered his presidential address, and in the evening the annual dinner of the Society was held in the Golden Lion Hotel, Stirling.

BRITISH Medical Association visitors to Toronto will have an opportunity of visiting the Mushoka Lakes District by an excursion train, which is announced to leave Toronto, on Saturday, August 25th. Other most interesting trips to Lake Nipissing and the Temagami Region have also been organised.

MEDICAL NEWS IN BRIEF.

Royal College of Surgeons of England. The New President.

A QUARTERLY meeting of the Council of the College was held on Thursday last when Mr. Henry Morris, consulting surgeon to Middlesex Hospital, was elected President. Mr. Edmund Owen, surgeon to St. Mary's Hospital and Mr. Rickman J. Godlee, Surgeon to University College Hospital, were elected Vice-Presidents. The following appointments were also made for the ensuing collegiate year :—*Hunterian Professors* —Mr. Wm. Sampson Handley, M.S.Lond., F.R.C.S. ; Mr. J. W. Thompson Walker, M.B.Edin. ; F.R.C.S. ; Mr. J. Howell Evans, M.B.Oxon., F.R.C.S. ; Mr. William Wright, M.B.Vict., F.R.C.S., of Birmingham University and Owens College, Manchester ; Mr. Cecil F. Beadles, M.R.C.S., L.R.C.P.Lond., F.R.C.S. *Arris and Gale Lecturers*—Mr. J. Faulkner Dobson, M.S.Lond., F.R.C.S., of the School of Medicine, Leeds ; Dr. Bertram L. Abrahams, F.R.C.P. *Erasmus Wilson Lecturers*—Mr. Willmott H. Evans, F.R.C.S. ; Mr. Reginald C. Elmslie, M.S.Lond., F.R.C.S. ; Mr. Kenneth, W. Goadby, M.R.C.S., L.R.C.P.Lond. The following resolution moved by Mr. J. Ward Cousins and seconded by Mr. R. J. Godlee, was adopted: "That, in the opinion of the Royal College of Surgeons of England, it is essential for the efficient working of the Midwives Act that adequate provision be made to secure just remuneration for professional services rendered by medical men when called into attendance by midwives practising under the Act." A letter was received from the Secretary to the Faculty of Medicine of Harvard University thanking the College for presenting to the Faculty a collection of prints and engravings of physicians and surgeons. On the recommendation of the Museum Committee it was decided to print Vol. III. of the second edition of the Museum Catalogue of the Physiological Series of Comparative Anatomy.

Royal College of Surgeons, Ireland.

Prize List, Summer Session, 1906.—Barker Anatomical Prize, £31 10s.—P. G. M. Elvery. *Carmichael Scholarship*, £15—C. Greer. *Gold and Silver Medals in Operative Surgery*—Gold, D. Adams ; silver, R. M. Bronte. *Stoney Memorial Gold Medal in Anatomy*—G. S. Levis. *Practical Histology*—R. Adams, First Prize (£2) and Medal ; O. W. J. Wynne, Second Prize (£1) and Certificate. *Practical Chemistry*—J. J. Lyons and P. I. Wigeder (equal), First Prize (£2) and Medal. *Public Health and Forensic Medicine*—T. C. Boyd and C. T. Cullimore (equal), First Prize, (£2) and Medal. *Materia Medica*—J. J. Lyons, First Prize (£2) and Medal ; H. W. White, Second Prize (£1) and Certificate. *Biology*—H. D. Gasteen, First Prize (£2) and Medal ; J. S. Pegum, Second Prize (£1) and Certificate. The lectures of the Winter Session will commence on Monday, October 15th.

Barker Anatomical Prize for 1907.—A prize of £21 is offered for competition, and is open to any student whose name is on the anatomical class list of any school in the United Kingdom. The preparations entered must be placed in charge of the Curator on or before April 30th, 1907. The prize is offered for a dissection showing the viscera in relation with the abdominal surface of the diaphragm. The relations of the common bile duct, which should be seen opened up along its entire length, to be fully retained. Conditions under which the competition is to be carried out :—1. The preparations must be sent to the Curator of the Museum, Royal College of Surgeons, each being marked with a fictitious signature, and accompanied by a sealed envelope bearing outside the same signature, and containing within, (*a*) The full name of the competitor ; (*b*) A declaration to the effect that the work of the preparation has been carried out by himself. The printed form necessary for this declaration can be obtained on application to the Curator. 2. The dissections are to be mounted in vessels fitted with glass covers, but the covers must not be sealed down. Earthenware basins and plaster of Paris settings are not compulsory if the specimens can be better displayed and preserved by other means. 3. No prize will be awarded unless sufficient merit be shown, 70 per cent. of the total marks being the minimum. The following is the scale of marks : (*a*) For the merit of dissection, 60 ; (*b*) for excellence of setting, 20 ; (*c*) for originality, 20 ; total, 100. Those dissections for which prizes are awarded become the property of the college. 4. Those competitors who enter dissections for which prizes are not awarded, but which show sufficient merit, may be refunded such amount of the cost of production as the Examiners deem fit. 5. The cost and risks of transport must be borne by the student. The College will not be responsible for any damage the preparations may sustain ; but those of unsuccessful competitors residing at a distance will be carefully re-packed and handed to the carriers for delivery at such address as may be specified by the student.—Arthur H. White, Curator of the Museum. *Extract from the will of the late Dr. Barker, formerly Curator of the Museum* :—"This Prize to be awarded by the Curator of the Royal College of Surgeons in Ireland for the time being, the President of the College, and the Professor of Anatomy of the University of Dublin."

Diphtheria in the Midlands.

A SERIOUS outbreak of diphtheria has occurred in the village of Fleckney, in Leicestershire, and is causing great alarm in the surrounding towns and villages. The epidemic has been prevalent for some months now, but recently the number of cases has increased to an alarming extent. Eighteen fresh cases have occurred in the last four days, and the inhabitants are in despair. Nearly half the houses in the village have been affected, and there have been several deaths.

Laryngological Society of London.

THE following have been elected Officers and Members of the Council for the ensuing session, 1906 7 : —*President*—J. B. Ball, M.D. *Vice-Presidents* — F. Willcocks, M.D., Charters J. Symonds, F.R.C.S., William Hill, M.D., and P. Watson-Williams, M.D. *Hon. Treasurer*—H. B. Robinson, F.R.C.S. *Hon. Librarian*—St. Clair Thomson, M.D. *Hon. Secretaries*—H. J. Davis, M.B., W. Jobson Horne, M.D. *Council*—Sir Felix Semon, K.C.V.O., M.D., Philip de Santi, F.R.C.S., J. Middlemass Hunt, M.B., S. Paget, F.R.C.S., and Attwood Thorne, M.B.

A Clean Bill of Health.

No case of notifiable disease has occurred in the district of Wadebridge, Cornwall, which has a population of 2,000, for two years. This speaks well both for the sanitary administration and for the healthiness of the district.

The Amalgamation of the London Medical Societies.

IN view of the present position of the negotiations between the Organisation Committee of the Scheme for the Amalgamation of the London Societies as it affects the Union of the Obstetrical and Gynæcological Societies, the Council of the latter Society has decided to summon a conference of its representatives with the Provincial Fellows. This conference will be held by kind permission of the Council of the Royal Botanical Society in the Museum, in the grounds of the Society in Regent's Park, on Thursday,

July 26th, at 4.30. Dr. Macnaughton-Jones has kindly arranged for refreshments for the Fellows in the grounds of the Society after the meeting.

A Serious Indian Medico-Legal Action.

RECENTLY a number of medical men, chiefly native practitioners, started a College of Physicians and Surgeons at Calcutta. The original and existing College of Calcutta have now entered a legal plaint in the High Court, charging the defendants with having wrongfully and illegally conspired to injure the said college in various ways; for having set up a bogus institution of the same name; alluring the students of the College, and also for having had recourse to diverse unfair means to lower the prestige of the college in the eyes of the public. A sum of Rs. 40,000 is claimed as damages by the College.

Diphtheria and Schools.

The Education Committee of the London County Council recommended that they should be authorised to refuse, during the presence of diphtheria in any district, re-admission to school of children excluded on account of diphtheria or sore throat until such children should have obtained a medical certificate of freedom from infection, based on a bacteriological examination. The recommendation was, after discussion, adopted.

AT a special meeting of Governors of the London City Orthopædic Hospital on July 10th, it was decided to agree to the amalgamation scheme that has so long been urged upon them by the Hospital Sunday and King Edward's Funds. The three hospitals, the Royal, the National, and the City Orthopædic will henceforth be merged in one institution.

PASS LISTS.

University of Birmingham.

THE following is a list of successful candidates in the Faculty of Medicine at the examinations in June, 1906.

Degree of Doctor of Medicine.—Thomas Webb Fowler, Robert Beatson Dennis Hird, Alfred Ernest Remmett Weaver.

Degree of Master of Surgery.—(*a*) Official, Frank Marsh; (*b*) Under ordinary regulations—Class I.—Alex Wathen Nuthall.

Degrees of Bachelor of Medicine and Bachelor of Surgery.—(*a*) Past students of Birmingham Medical School.—Class II.—Frank Newstead Deakin, Charles Henry Maskew. (*b*) Under ordinary regulations—Class II.—Reginald Hudson Astbury, John Staines Austin, Arthur Cecil Hincks, Claude Johnson, Harold Bruce Jones, Walter Rowland Southall Roberts.

Fourth Examination for the Degrees of M.B., Ch.B.—Class I.—James Fenton, Arthur Addison Sanders, Francis Brett Young. Class II.—Edward James Boome, Henry Neville Crowe, Eric Thomas Gaunt, John Kennedy Gaunt, Philip James Mason, Nevill Coghill Penrose, Arthur John Smith, Rupert Wesley Thompson, Norman Valentine Williams.

Third Examination for the Degrees of M.B., Ch.B.—Part I.—Pathology and Bacteriology.—Class II.—John Adams, Charlotte Bailey, John Dale, George Henry Chavasse Mold, David Priestley Smith, Edward Vernon Whitby. Part II.—Materia Medica and Pharmacy.—Class I.—John Adams, John Dale, Harvey Atkins Evans, Edward Vernon Whitby. Class II.—Charlotte Bailey.

Second Examination for the Degrees of M.B., Ch.B. Class II.—Walter Charles Blackham, Norman Alexander Boswell, Harold Gordon Browning, Humphrey Francis Humphreys, Violet Maud McCready, Cranston Walker, Kenneth Douglas Wilkinson. Passed in part of the examination.—James Henry Bampton (anatomy and comparative anatomy), John Selwyn Edwards (anatomy and physiology), Carl Euclid Molino (anatomy and physiology), Ethel Annie Waldron (anatomy and physiology), Harold Arthur Whitcombe (anatomy and physiology), Henry Wilks (anatomy and comparative anatomy).

First Examination for the Degrees of M.B., Ch.B.—Class II.—Eric Walter Assinder, Oscar Madeley Holden, Elizabeth Stephens Impey, Lionel Gilbert Jordan, Ronald Douglas Nelson, Henry Richmond.

Degree of Bachelor of Dental Surgery.—Class I.—William Bowater.

Trinity College, Dublin.

THE following have passed the Intermediate Medical Examination—Part I.:—John L. Phibbs, Richard P. Hadden, Albert J. Stals, and Thomas A. Hughes, Passed on High Marks; Adams A. M'Connell, Herbert V. Stanley, Cecil P. Smyly and William A. R. Spong (equal), Duncan F. Hunter, Peter H. Lemass, Arthur H. Laird, John D. Kernan, George B. M'Hutchison and William N. Watson (equal), Richard J. Attridge and Eric J. Powell (equal) Charles G. S. Baronsfeather, Frederick R. Sayers, Harold T. Sugars. *Purser Medal in Institutes of Medicine*—Richard P. Hadden.

The following have passed the Final Medical Examination—Part II.—*Midwifery.*—Gustav W. Thompson (passed on High Marks), Edward Gibbon, Robert B. Jackson, Thomas L. de Courcy, Cecil T. Conyngham and Henry B. Leech (equal), Henry D. Woodroffe, George Dougan, Wilfred L. Hogan and Thomas B. W. MacQuaide (equal), Charles G. Sherlock and Theodore C. Somerville (equal), Francis W. H. Bigley and Thomas J Cobbe, (equal) John B. B. Whelan, Madeleine S. Baker, Albert J. T. M'Creery, James E. M'Farlane, Ernest C. Crawford and Joseph H. Elliott (equal).

University of Glasgow Final Professional Examination.

THE following candidates have passed the Fourth (Final) Professional Examination:—

For M.B., C.M.—Robert Stewart M'Kim, M.A.

For M.B., Ch.B.—James Montgomery Anderson, John Anderson, M.A., B.Sc., Thomas Barbour, M.A., B.Sc., George Duncan Morrison Beaton, Charles Burns, John Miller Hopkins Caldwell, William Rome Cammock, George Campbell, William Archibald Campbell, Henry Howard Christie, John Sawers Clark, M.A., James Coutts, Thomas Lawson Craig, Arthur Muir Crawford, James Richan Drever, M.A., Ernest Milne Eaton, William Gilbert, William Gilfillan, Arnold Harris Gray, Robert Neil Guthrie, Charles Francis Dyer Hammond, William Towers Hardie, Robert M'Cowan Hill, Alexander Hunter, Archibald Yuill Hutchison, John Keys, James Dunlop Kidd, William Hendrie Kirk, Alexander M'Call, Thomas M'Cririck, M.A., B.Sc., David Macdonald, James M'Farlane, John Robert M'Gilvray, William Anderson M'Kellar, William Ferguson Mackenzie, Norman Smith MacNaughtan, Alister Argyle Campbell M'Neill, Elizabeth Maud M'Vail, Andrew Alexander M'Whan, Florence Mann, William Hislop Manson, M.A., Robert Marshall, John Miller, William Miller, Peter Mitchell, M.A., Edith Oversby, James Hogg Paul, Agnes Picken, M.A., Alexander MacMillan Pollock, Thomas Hood Rankin, Vera Dagmar Reis, Frederick Gordon Robertson, William James Rutherfurd, William Hermann Sieger, William Smellie, Thomas Baillie Smith, James Stevenson, John Stevenson, Thomas Strain, David Laurence Tate, Charles Samson Thomson, George Haswell Wilson, James Wyper, John Young (Mount Vernon), Morris Youdelevitz Young.

The following passed with distinction in the subjects indicated:—

In (*a*) *Surgery and Clinical Surgery* (*b*) *Practice of Medicine and Clinical Medicine*—Robert Stewart M'Kim, M.A. (old regulations); Charles Samson Thomson. In (*a*) *Practice of Medicine and Clinical Medicine* (*b*) *Midwifery*—William Smellie. *In Surgery and Clinical Surgery*—James M'Farlane, Elizabeth Maud M'Vail, Peter Mitchell, M.A.; Agnes Picken, M.A., John Stevenson, John Young (Mount Vernon)., Morris Youdelevitz Young. *In Practice of Medicine and Clinical Medicine*—John Anderson, M.A., B.Sc., Arthur Muir Crawford, James Richan Drever, M.A., Arnold Harris Gray, William James Rutherfurd. *In Midwifery*—Andrew Alexander M'Whan, James Stevenson, George Haswell Wilson.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS.

ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT MEDICAL LITERATURE.

Rise of Temperature from Suggestion in the Tuberculous.—Lorenz (*Beit. z. Klin. der Tuberk.*, Wurzburg 1906.) relates his experiences with a number of tuberculous patients who were given sham injections of tuberculin. His tables show an almost regular increase in temperature after a sham injection in 44 out of 200 persons tested. The excitement and the suggestion send the temperature up, although none of the supposed tuberculin was really injected. His experience suggests that it might be wise to test the influence of suggestion in this way before really injecting the tuberculin later. A rise of half a centigrade degree can be accepted as a positive reaction to the tuberculin. It should be computed from the temperature noted after the sham injection, allowing for the rise due to effects of suggestion. The sham injections were liable not only to send up the temperature, but also to affect the general health. It was noticed sometimes that those patients who had the most pronounced rise of temperature after a series of sham injections failed to show any rise when a genuine injection was given. Another fact noted was that the suggestive reaction was generally more pronounced when the organism was depressed from any cause, a slight cold or inflammatory process in a tooth or the like. D.

Reduction of Salt in Diet in Scarlet Fever.—Pater (*Presse Med.*, Paris, 1906) reports the results of salt starvation in 15 cases of scarlet fever. They demonstrate beyond question, he thinks, that this method of treating scarlet fever is absolutely simple and harmless, while it protects against complications, especially on the part of the kidneys. He found in his cases the course of the disease was shorter than usual, convalescence commencing earlier. If albuminuria was noted at first it subsided as salt was dispensed with. Dopter has also reported similarly favourable experiences, all tendency to nephritis being apparently averted. D.

Action of Iodine in Experimental Arterial Affection.—Koranyi (*Deut. Med. Woch*, Berlin, 1906) mentions experiments with iodine in arterial necrosis produced by adrenalin. Twenty-three rabbits were treated with adrenalin and 11 with subcutaneous administration of iodine at the same time. The results showed that the necrosis of the arteries which inevitably followed the injections of adrenalin could be prevented by simultaneous injection of iodine. He suggests that this observation may prove of therapeutic importance. D.

Epileptiform Seizures of Pleural Origin.—Roch (*Revue de Med.*, Paris, 1906) reviews 54 cases of convulsions suggesting epilepsy, in which the inciting cause was some affection involving the pleura. The pleurisy in some cases favoured the development of convulsions primarily due to other causes, but in others the pleurisy was evidently the sole inciting cause. The action is manifestly a reflex phenomenon. It was observed unmistakably in four well-defined cases. This assumption is also sustained by the cases on record of severe nervous disturbances in pleuritis, independent of operative trauma, such as coughing, hemiplegia, or sudden death. D.

Atropin and Strychnine combined a Remedy for Sea-Sickness.—Brig.-Gen. A. H. C. Girard (*Journ. Amer. Assoc.*, June 23rd, 1906) gives a summary of his investigations extending over several years in the treatment of sea-sickness. He states that in almost every instance a hypodermic injection of gr. 8-$\frac{1}{100}$ atropin sulph. with gr. 8-$\frac{1}{60}$ strych. sulph, is readily borne by adults and causes no disagreeable sensation. This may be taken at the commencement of a voyage, or when the sea commences to be rough, or at the advent of a storm causing nausea. This dose is at times not sufficient with persons refractory to the action of belladonna, and may have to be repeated twice at hourly intervals before incipient dryness of the throat gives warning that atropinism has been reached, when in every instance the symptoms of sea-sickness disappeared. As a rule one dose is sufficient for a whole voyage, apparently overcoming the disturbance until the voyagers acquired their "sea legs," but in a long trip with severe weather occasional doses are required to keep up the effect. He regards the treatment as undoubtedly specific. D.

Orientalism.—Dr. Work Dodd contributes a most interesting article to the *Lancet* for June 23rd. with the above title. In it he describes cases in which a gradual transition from a European to a Mongolian type took place. The first patient was seen for the first time in 1898, and was then a strong vigorous man, weighing over sixteen stone, was of a florid type and had light brown hair. He was at that time operated on for ptosis and left hospital soon after. He returned in June, 1899, and was then found to be much changed in appearance. He was only 11 stone 11 lbs., in weight, his hair was of a mousy colour, and no longer grew rapidly; he was more or less apathetic and his general facial aspect had gained for him the soubriquet of "The Japanee" amongst his fellow workmen. At the present time he retains an Eastern appearance, and has developed certain nervous phenomena which may perhaps be ascribed to old syphilis of which there is a definite history. Sexual desire is absent, and the testes are atrophied,; the thyroid gland cannot be felt, and there is semi-atrophy of the tongue. The second case was that of a man, æt. 48, with a doubtful syphilitic history, and with similar change in appearance, while in a third well-marked case a definite history of syphilis was present. The writer suggests that these cases may perhaps form a type of themselves which may be just as distinct and important as acromegalic and myxœdematous individuals. M.

The Radio-Therapeutics of Ringworm.—Sabouraud (*The Brit. Journ. Dermatology*, June, 1906) describes this treatment as devised and used by him at the Hospital of St. Louis, Paris. The method itself is very simple. and the results have been very encouraging. The ringworm patient having been examined and the patches recognised, the area which it is necessary to depilate is marked out by localisers. In cases where the entire scalp has to be depilated the head is marked out in circular areas, and each of these circles so marked out, is exposed in turn. After each exposure the part acted on is covered with a disc of lead, held on by an elastic band, to prevent the risk of exposing the same spot to a second application. The length of the exposure is timed by the alteration caused by the rays in the pastilles of Bristol paper coated with an emulsion of platino-cyanide of barium, in collodion with acetate of starch. These pastilles are placed in the path of the rays midway between their source and the scalp, that is to say, 7½ centimetres from the anticathode. When the exposure is completed the pastille should have changed colour to the standard tint of the radiometer. "This tint is such that when the pastille placed at 7½ centimetres has taken its colour the skin placed at 15 centimetres has received exactly the quantity of X-rays necessary to ensure the complete

depilation of the region without irritation, without dermatitis, and without compromising the ultimate re-growth of hair." In Paris Sabouraud has found this treatment most successful, the patch of ringworm being cured with certainty by a single exposure. It has been found possible to abolish in the hospitals a great part of the accommodation given up to ringworm and to apply this to other purposes. As an example of this result, Sabouraud gives the following figures. A ringworm patient treated in a hospital in Paris costs 2·80 francs per day to the Assistance Publique; treated in the way mentioned, the only cost is the X-ray exposures (of which from one to twelve may be required in order to denude the entire head), the cost of which is about 50 centimes each. "On January 1st, 1904, I was able to give up to the Assistance Publique a group of buildings capable of holding 150 beds. These 150 beds are to-day given over to two new departments of the hospital, one for medicine, one for surgery. Now a bed in a hospital in Paris represents on an average a capital of 10,000 francs, 150 beds represent therefore 1,500,000 francs. In six months I shall be able to give up to the Administration another group of buildings capable of holding about 100 beds—that is, a million of francs." K.

The Present Treatment of Syphilis.—Butt (*The Med. Chronicle*, June, 1906) discusses this problem in the light of his experience as an army surgeon both at home and in India. Butt is in favour of beginning the treatment as soon as any induration of the lymphatic glands can be detected, and continuing this treatment till resolution of these glands has occurred. He is in favour of the introduction of the mercury by subcutaneous or intra-muscular injection, and maintains that "so long as the excretory functions are normal one grain of metallic mercury, administered intramuscularly, may be looked on as a safe dose." If there is evidence of change in the local manifestations of the disease this dose is continued weekly, but should no change be apparent then an intermediary dose of half a grain is given on the third or fourth day, and if necessary repeated in increased doses. The injections are continued until the glands soften or lose their characteristic hardness, provided there is no evidence of mercurialisation. The cream now used in the medical service of the army, contains one grain of metallic mercury in ten minims. according to the following formula :—Hydrargyri, 1 oz.; Adeps lanæ (B.P.) 4 oz.; paraffin liquid (carbolic at 2 %) 10 oz. The injections are to be made above and along a line connecting the upper border of the great trochanters in each gluteal region alternately. K.

The Etiology of Eczema.—MacLeod (*Practitioner*, July, 1906) discusses this subject in the light of the more recent communications about it with the object of defining the present state of our knowledge on the subject. A precise definition of the disease does not appear to him possible, and he contents himself with a brief description of the complex symptoms to which the name is generally applied. At present there appear to be four opposing hypotheses concerning the nature and causation of eczema: (1) that it is parasitic; (2) that it is due to a variety of irritants both internal and external acting on a predisposed individual; (3) that it is due to nerve derangement; (4) that it is a symptom, not a disease, merely a cutaneous reaction to irritants in predisposed individuals. The explanation of eczema as due to local parasitic infection which at one time had the support of Unna has now been generally abandoned by dermatologists. The view that eczema is the cutaneous manifestation of some circulating toxin is at present in some vogue, but lacks proof, and the same may be said for the hypothesis of nerve causation. Many writers, notably Brocq, of Paris, and Hall, of Sheffield, maintain that eczema is merely a reaction of the neuro-cutaneous apparatus to external irritants in predisposed individuals, and this view MacLeod appears to adopt provisionally, while counselling us to avoid hasty generalisations, and to keep an open mind on the subject. K.

Landry's Paralysis.—Schütze records a case (*Berlin. Klin. Woch.*, 1906, No. 7) of acute ascending paralysis as a complication of typhoid fever. The patient was a Russian soldier, and was admitted with typical enteric symptoms. About eight days after the cessation of the pyrexia there was again a slight rise of temperature, accompanied by slight sensory disturbances, and followed by slight paralysis of the pelvic and abdominal muscles, and also of the muscles of the lower limb and trunk. Later there developed paralysis of the arms, Cheyne Stokes respiration, facial paralysis, and strabismus. Electric excitability was retained and there was no reaction of degeneration. Under treatment by mercury and other drugs, the symptoms rapidly disappeared within four weeks.

Donath (*Wiener Klin. Woch.*, 1905, No. 50) also records a case of Landry's paralysis which commenced with weakness of the feet and hands, and was rapidly followed by paralysis of the limbs, and by symptoms pointing to bulbar inflammation, namely dyspnœa, aphonia and dysphagia. Facial paralysis, and paralysis of the pupil reflex also occurred. Some sensory disturbances were present, and the electrical excitability of the muscles was increased. The cerebro-spinal fluid was increased in amount, and the patient lived four months after the onset of the symptoms. M.

Prurigo Lamphadenique.—Dubrieuilh reports (*Ann. de dermat.*, 1905, p. 665) two cases of this disease, bringing the total number of these on record up to eighteen in all. In both cases there was a combination of general lymph gland enlargement supposed to be of the nature of Hodgkin's disease, with the most intense and distressing pruritus. In the first case lymphomatous masses were present in the neck, axilla and in the mediastinum, causing in the last-named place collapse of the left lung. Microscopical examination showed the presence of numerous small lymphoid masses in the deeper portions of the cutis, and to the presence of these the writer attributes the sensory symptoms. He regards it as far more likely that such structures could cause the trouble than that the itching could be due, as was formerly supposed, to a toxin produced by the diseased glands. Treatment he found to be of little use, and was purely symptomatic. M.

Paroxysmal Hæmoglobinuria.—Langsteiner and Donath (*Zeitchrift f. Klin. Med. Bd.* 58, p. 173) have determined as the result of previously recorded investigations that the hæmoglobinuria in the above type of case is produced by the action of a hæmolysin. When one makes a mixture of red cells from a hæmoglobinuric or from a normal person, with some hæmoglobinuric serum and raises the mixture to body temperature hæmolysis at once takes place. This hæmolysis will only occur when the serum of a hæmoglobinuric is employed, and leads the authors to believe that the red cells are able to absorb a definite toxin from such serum. The authors have lately confirmed this result by the investigation of three new cases, bringing the total number up to six. They have also now examined 195 normal individuals, and in every case with a negative result. They are inclined to think that the toxin may be the result of syphilis, since they have obtained a history of old specific disease in all of their cases. M.

NOTE.—*A Summary will appear each week in the following sequence :*—(1) "*Recent Medical Literature.*" (2) "*Recent Surgical Literature.*" (3) "*Recent Gynæcological and Obstetrical Literature.*" (4) "*The Recent Literature of Physiology and Pathology.*"

NOTICES TO CORRESPONDENTS, &c.

☞ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to 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 proofs.

ILLEGAL TREATMENT OF DISEASE BY CORPORATIONS.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—I am instructed to forward you for publication the following resolution adopted by the Bradford Division of the British Medical Association at a meeting held on June 12th :—

"That in the opinion of this meeting it is highly undesirable that the City Council should carry on the treatment of disease for profit through officials at the Corporation Baths, who are not legally qualified medical practitioners, who treat diseases which are not of an epidemic character; that such practice is illegal, the Council having no powers authorising them to carry out such treatment; and that a copy of this resolution be forwarded to the Mayor, to the medical journals (*Lancet*, *British Medical Journal*, and MEDICAL PRESS AND CIRCULAR), and to the General Medical Council."

Hoping you will publish it, and thanking you in anticipation,

Believe me, yours sincerely,

Bradford, July 15th, 1906. JAMES METCALFE, Hon. Sec.

DR. J. E. SAWDON.—We have the series of Clinical Lectures by Mr. Jonathan Hutchinson in hand, and their publication in this journal will commence with the first number in August.

"THE NEWSIEST AND MOST READABLE MEDICAL PUBLICATION."

THE Editor of the *Medical Monthly*, in writing us that our weekly number had not reached him lately, says: "The MEDICAL PRESS AND CIRCULAR is one of the newsiest, most readable medical publications with which we are cognizant, and we take the liberty frequently of quoting from its pages." We thank our journalistic confrère for this expression of his opinion, which we hope is shared by our readers generally. We take it that the recent steady increase in our subscription list is a confirmation of the view of our correspondent.

L. H.—The cost of motor-bicycles and their handiness are recommendations, but you will find that for regular use a car will prove the better investment. Nevertheless, we know of one that has been in pretty hard use for over two years, but we think this must be exceptional.

R. S. T.—The book is published by Longmans, Green and Co., 39 Paternoster Row, E.C.

QUALITY OF CITY OF LONDON MILK.

AT the meeting of the Court of Common Council on Friday, the Chairman of the Sanitary Committee, in answer to a question with reference to the adulteration of milk in London, said that the last annual report of the Medical Officer of Health for the City showed that the ratio of adulteration was rapidly decreasing. In 1901 it was 21 per cent.; in 1902, 13·3 per cent.; in 1903, 11·6 per cent.; in 1904, 7·5 per cent.; and in 1905, 7·5 per cent. The average for the whole Metropolis was 12·5 per cent. Consequently, if a man wished to drink milk, he should come into the City to do so.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JULY 18th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. J. Clarke: Clinique. (Surgical). 5.15 p.m. Lecture:—Dr. P. Stewart: Recurrent and Transient Palsies.

THURSDAY, JULY 19th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m. Lecture:—Mr. T. Walker: On the Methods of Estimating the Function of the Kidneys.

FRIDAY, JULY 20th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. M. Yearsley. Clinique. (Ear).

Vacancies.

Egyptian Government.—Ministry of Education.—Professor of Midwifery and Gynæcology. Salary £400 a year, with private practice. Applications to the Director, School of Medicine, Cairo, Egypt.

Egyptian Government.—Ministry of Education.—Medical Tutor and Registrar to Kasr-El-Ainy Hospital. Salary £400 a year. Applications to the Director, School of Medicine, Cairo, Egypt.

Bradford Poor Law Union.—Resident Assistant Medical Officer. Salary £100 per annum, with rations, apartments, and washing. Applications to George M. Crowther, Clerk to the Guardians, Union Offices, 22 Manor-row, Bradford.

Herefordshire General Hospital.—House Surgeon. Salary £100 per annum, with board, furnished apartments, and washing. Applications to W. A. W. Price, Secretary.

University of Manchester.—Junior Demonstrator in Physiology.—Salary £100 per annum. Applications to the Registrar.

Victoria Hospital, Burnley.—Resident Medical Officer. Salary £100 per annum, with residence, board, and washing. Applications to F. A. Hargreaves, Hon. Sec., 7 Grimshaw Street, Burnley.

The Hartlepools Hospital. House Surgeon. Salary £100 per annum, with board, washing, and lodging in the Institution. Applications to Robert Edger, Secretary, 15, Town Wall, Hartlepool.

Medical School, University College Hospital, London.—Secretary. Salary £150 per annum. Applications to the Secretary of the Hospital.

Sheffield Union Hospital.—Resident Medical Officer. Salary £100 per annum, with apartments, rations, &c. Applications to Albert Edward Booker, Clerk to the Guardians, Union Offices, Westbar, Sheffield.

Lincoln Lunatic Hospital.—Assistant Medical Officer. Salary £100 per annum, with board, &c.—Applications to the Medical Superintendent, The Lawn, Lincoln.

East Riding Lunatic Asylum, Beverley.—Second Assistant Medical Officer. Salary £150 per annum, with board, apartments, and washing. Applications to C. W. Hobson, Clerk to the Visiting Committee, Beverly.

Windsor and Eton Royal Dispensary and Infirmary.—House Surgeon. Salary £120 per annum, with residence, board, laundry, and attendance. Applications to Geo. P. Cartland, Secretary.

Hospital for Sick Children, Newcastle-on-Tyne.—Male Resident Medical Officer. Salary £100 per annum, with board, lodging, and laundry. Applications to Alf. E. Birch, Secretary, Secretary's Office, Hospital for Sick Children, City Road, Newcastle-on Tyne.

East London Hospital for Children and Dispensary for Women, Shadwell, E.—Pathologist and Registrar. Salary £100 per annum. Applications to W. M. Wilcox, Secretary.

Preston Royal Infirmary.—Senior House Surgeon. Salary £100 per annum, with board, lodging, and washing, &c. Applications to Walter Davies, Secretary, 5 Winckley Street, Preston.

The Cambridgeshire, &c., Asylum.—Second Assistant Medical Officer. Salary £120 per annum, with board, lodging, and attendance. Applications to T. Musgrave Francis, Clerk to the Visitors, 18 Emmanuel Street, Cambridge.

Royal National Hospital for Consumption, Ireland.—Two Physicians as (1) Resident Medical Officer; (2) Assistant Medical Officer. Salaries £100 and £50 per annum respectively. Immediate application to the Secretary, 13 South Frederick Street, Dublin. (See advt.)

Appointments.

FERGUSON, ROBERT J., M.D., M.Ch., M.A.O.R.U.I., F.R.C.S.Eng., Gynæcological Registrar to the Kensington General Hospital.

GRAHAM, J., M.B., Ch.B.Edin., Clinical Assistant to the Chelsea Hospital for Women.

HUSTLER, G. H., M.B., Ch.B.Leeds, Assistant House Surgeon at the Royal Devon and Exeter Hospital, Exeter.

LAING, E. A. R., L.R.C.P. and S.Edin., L.F.P.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Rochford District of the county of Essex.

MACKINTOSH, F. I., M.B., M.S.Aberd., Certifying Surgeon under the Factory and Workshop Act for the Strathmiglo District of the county of Fife.

ROSE, FRANK A., M.B., B.C.Cantab., F.R.C.S.Eng., Assistant Surgeon to the Hospital for Diseases of the Throat, Nose, and Ear, Golden Square.

SAWYER, JAMES E. H., M.A., M.D.Oxon, M.R.C.P.Lond., Casualty Assistant Physician to the General Hospital, Birmingham.

SHEPPARD, AMY, M.B.Lond., D.P.H.Cantab., Ophthalmic Surgeon to the New Hospital for Women and Children, Euston Road.

STEVENS, W. MITCHELL, M.D.Lond., M.R.C.P.Lond., Lecturer in Materia Medica and Pharmacology to the University College of South Wales and Monmouthshire, Cardiff.

Births.

CORY.—On July 10th, at Manor House, Soham, Cambs., the wife of C. G. Cory, M.R.C.S. and L.R.C.P., of a son.

FIELD.—On July 11th, at Zurich, the wife of H. Havilland Field, M.D., of a daughter.

KING.—On July 10th, at St. Leonards, Osmaston Road, Derby, to Dr. and Mrs. J. W. King—a son.

PRIDMORE.—On July 12th, at "Villa d'Este," Ryde, Isle of Wight, the wife of John Walter Pridmore, M.R.C.S., L.R.C.P.Lond., of a daughter.

Marriages.

ATKINSON—ELLIN.—On July 10th, at St. Andrew's Church, Sharrow Sheffield, William Atkinson, M.A., M.B., M.R.C.S., L.R.C.P., youngest son of J. P. Atkinson, Esq., M.D., Saffron Walden, to Constance, youngest daughter of Arthur R. Ellin, Esq., of Sharrow, Sheffield.

CAIE—KILNER.—On July 10th, at St. Mary's Church, Bury St. Edmunds, by the Rev. H. Ingate Kilner, Rector of Saxham Parva, William James Caie, M.A., M.B., Ch.B., elder son of the late Rev. William Caie, of Aberdeen, to Susan Christina, eldest daughter of Charles Scott Kilner, M.B., C.M., D.P.H., of Bury St. Edmunds.

NEWBOLT—ELLIOT.—On July 11th, at St. Bride's Church, Liverpool, by the Rev. Bernard C. Jackson, M.A., George Palmerston Newbolt, M.B., F.R.C.S., of 42 Catharine Street, to Lilia, only daughter of the late John Elliot, Esq., Canonbie, Dumfriesshire.

SIDDONS—WALSH.—On July 11th, at St. Augustine's Church, Edgbaston, Reginald Alfred, second son of Alfred H. Siddons, of Highfields, West Bromwich, to Mary Elizabeth Jane, only daughter of the late Saml. Walsh, B.A., M.B., L.R.C.S.I. (T.C.D.), and Mrs. Stubbins, of Edgbaston.

Deaths.

BREACH.—On July 11th, at Yattendon, Berks, James Henry Breach, M.R.C.S., aged 51.

MAY.—On July 12th, at Slough, after years of suffering, Louisa daughter of the late Geo. Hy. May, M.R.C.S., of Exeter.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

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NOTES AND COMMENTS.

Four Lectures by Mr. Jonathan Hutchinson.

WE have much pleasure in drawing attention to a series of four clinical lectures by Mr. Jonathan Hutchinson which have been specially reported for THE MEDICAL PRESS AND CIRCULAR. The series will commence in our forthcoming issue of August 1st. A special interest will be attached to these articles inasmuch as two of them deal with various phases of syphilis, one being the transmission of that malady to the third generation, and the other its relation to tuberculosis. The subjects of the remaining two lectures are tuberculosis in relation to diseases of the skin, and affections of the same organ caused by insects. The clear, learned and philosophical treatment of these subjects by so distinguished an authority cannot fail to render these articles of widespread interest.

Pregnancy and Murder.

OUR readers may remember the case of a woman tried at the last Cornwall Assizes, and sentenced to death for murder. The execution was postponed by the judge on account of pregnancy, a plea which was duly put forward by the defence. The child had since been born, and lived only a few hours. At the inquest the medical officer said that the child was born prematurely, and that in view of her condition the woman ought never to have been tried until after the confinement. We are glad to notice that this opinion met with a sympathetic reception at the hands of the Coroner and jury, and we hope it will be brought before the Home Secretary. It is a relic of feudal barbarity that a woman advanced in pregnancy should be subjected to the awful ordeal of a trial for her life, and it is small wonder that a wretched infant prematurely born as the result of the mother's anxiety and trepidation should not survive his birth for twenty-four hours. When it is considered that a pregnant woman may be charged with a murder of which she is perfectly innocent, the imagination revolts.

Removal from Hospital without Legal Consent.

ANOTHER isolation hospital case which raises a practical point of some interest occurred lately at Edinburgh. It appears that a boy named MacKenzie was certified to have diphtheria and removed to the Loanhead Fever Hospital. His mother visited him at the hospital, and, being dissatisfied with things, came with his father the next day and removed the boy. The hospital being a long way from their home, a cab was taken for the invalid. The father and mother were summoned at the Sheriff's Court for removing their boy "without legal consent," and though the Sheriff spoke sympathetically he was obliged to fine them both. Now if a patient can legally be detained in a hospital, as this case seems to show is possible in Scotch law, the isolation hospital assumes an importance in national life that cannot be overlooked, for it becomes like a prison or lunatic asylum, but without their safeguards. In England there is no power of detention without a magistrate's order, and even then we suspect most medical superintendents would be loth to detain a patient forcibly.

Medical Reports on Police Witnesses.

A MATTER touched on in these notes last week has received further illustration at Salford. The Stipendiary of that town, while hearing a remand case of assault, was told by the Chief Detective-Inspector that sufficient information as to the patient's state was not forthcoming from the hospital. The medical officer was then called, and the magistrate asked him why the constable could not be given the information at the institution in question. To this Dr. Wardleworth replied that a medical man was entitled to a guinea for a report on a case, and that in this particular instance the question was one of prognosis and not merely one of how the patient was progressing. In the course of further argument it appeared that one policeman came and asked as to the patient's state, of which he was duly informed, and that then another officer arrived and asked questions as to his probable progress. Dr. Wardleworth told him that he was willing to give such a report in the usual form and at the usual fee. Eventually the magistrate remanded the prisoner and said the police would make inquiry as to the child's state from time to time. Here again a matter involving skilled opinion was in question, and the State, as represented by the magistrate, practically refused to tender the medical officer a fee for giving an expert report. It is characteristic of the usual sweating of the profession that even the officers of the law pooh-pooh the bare idea of paying for a medical opinion.

LEADING ARTICLE.

THE NEWSPAPER PRESS AND QUACKERY

HOWEVER difficult it may be to believe it, we are bound to assume, and we shall at any rate for the present assume, that the consummate men of the world who own and manage the great London papers, are not fully aware of the nature of the traffic in which they are assisting by the indiscriminate admission of quack advertisements to their pages. If we have not in former articles already said enough to show them the need at least for serious inquiry, we trust that in the end we shall have done so. We have previously pointed out that the mischief wrought by quackery may amount to mere pocket-picking, or to the direct or indirect causation of unnecessary suffering, misery, and death. The least harmful form of quack imposture is that confined solely to the concoction and sale of such things as hair lotions and cosmetics. Some of these preparations may be pleasant to use, but in so far as they promise to make hair grow or to improve the condition of the skin they are with rare exceptions easily demonstrable swindles. It is especially fraudulent in many cases to undertake the cure of a "bad complexion" by local treatment of any kind alone, since the conditions often depend upon disorders of the general health. Many vendors of cosmetic preparations, however, use them as a bait to attract customers for personal treatment. The dupes are nearly all women —women simple, weak, or foolish. The quack with a sufficiently keen eye for character has little difficulty in picking out those who can be most easily robbed. Cases of extortion of this kind can be related by most family doctors of wide experience to whom the details have been confided by patients. The safety of the quack in such instances lies in the fact that there is hardly any wrong a sensitive or nervous woman will not endure rather than publicly expose her folly in a court of law; but every now and again such an exposure does take place. For instance, a few months ago a woman made an appeal for assistance to a London magistrate. She stated she was a lady's maid, and having developed some unsightly affection of the skin of the face, detrimental to her employment, she had been induced by an advertisement in a prominent London paper which she named to apply to a lady skin specialist. It is significant that the quack's name was not given in any newspaper report of the case. The quack, whom the woman imagined was a qualified doctor, had undertaken to cure her for £25. She paid in advance the sum demanded, a great part of her savings, and having undergone the treatment found her malady worse than before. The magistrate declared that he was unable to assist her. In the rare cases of a similar kind in which better advised legal methods are adopted the quack is usually induced to give up his plunder, and even to pay damages as well, rather than have his methods brought to light in a court of law. Cosmetic quackery, "beauty doctoring," and quack dentistry—the fixing of marvellous artificial teeth—are among the safest games for the impostor to follow, first because of the gullibility of the women patients and the ease with which they can be intimidated; and secondly, because, however gross the malpractice, the possible death of a patient and a charge of manslaughter need hardly be considered. These examples of sordid rascaldom may no doubt be easily scoffed at by the cynical, but, admitting that the injury to health to which their practices give rise is not commonly serious, it must be remembered that, in the words of a *Times* leading article, "they bring about the still greater evil of maintaining in prosperity and luxury some of the most complete and finished of the many impostors who are parasitic upon modern civilisation!" The rapid increase of these social pests at the present day is mainly due to the fact that leading papers, including the *Times*, now freely accept almost every class of quack advertisement. The editors dare no longer attack quackery. They can never be sure that a paid puff of the quack they are denouncing may not appear in the same issue of their paper or even in juxtaposition to their article, and vouched for by the conductors of the advertising department. The cosmetic quack, the hair restorer, the "beauty doctor," the quack dentist, and their tribe are only less criminal than other species of medical quacks, because the field of their operations does not oblige them to tamper with matters of life and death. To the more serious forms of quackery we shall return in future articles.

NOTES ON CURRENT TOPICS.

Science and the School Hamper.

TRULY there is nothing either too great or too small to escape the attention of omnivorous science. Every detail of our lives, the air we breathe, our food and drink, our clothes, exercise, sleep, our homes, workshops, offices, schools, in a word, everything that enters into the complex modern environment, becomes the subject of an elaborate essay. Many a long-cherished usage has in this way faded out of existence beneath the ban of science. The three-bottle man has vanished along with the stage coaches, while wholesale capital punishment for trifling offences has given place to scientific criminology. Science has so far purified water supplies that cholera has been banished from the United Kingdom, although water-borne typhoid fever is likely to thin our ranks so long as we are content to drink sewage-polluted river water in London and in various other great cities. In the long run, however, even pure water will come to sanitarians who are content to wait. Meanwhile we are sharply reminded by Dr. Symes, at the Bristol Sanitary Congress, that nothing is sacred to the restless hand of Science. Her last and, in some ways, most audacious feat has been to attack the school-

boy's hamper. The gist of the complaint is that children, after the rich home fare of the holidays, cannot relish plain school food. They complain to parents, who forthwith despatch extra pocket-money and double-sized hampers. "In either case," says Dr. Symes, "the result is the same; namely, that the child eats a supply of undesirable food between meals and still further neglects the food provided at meal-times." In our early days the schoolboys with whom we were acquainted tackled both supplies without turning a hair. To our mind there could hardly be a more certain sign of physical degeneration in the nation than the standard of public school health that leads an eminent authority to threaten one of the earliest and most prized of our national landmarks—the school hamper.

Motors and Influenza.

IT is usual to associate influenza with the warmer months of the year—a belief founded on bitter and oft-repeated experience. Of late medical men have learnt that this most undesirable catarrh is associated with summer road dust. The connection is probably due in nine cases out of ten to an inflammatory condition of the nasal mucous membranes, set up by the presence of minute irritant particles. If all this be true it follows that motors, which raise dust galore, to say nothing of their noxious fumes, must be answerable for an untold amount of influenza. As a matter of fact, the whole of the United Kingdom at the present moment is being swept by a wave of influenza, happily of a somewhat mild type. The cause of the outbreak is most likely to be found in motor dust, which is distributed just as widely as the epidemic. Truly the havoc wrought by motors is manifold and endless.

The "Standard" and Quackery.

IN the *Standard* of July 16th appears a particularly obnoxious advertisement of an "Institute" for the cure of all sorts of diseases. This advertisement appears side by side with ordinary news, and from the type and get-up of the article it might easily be mistaken for such by an ordinary reader. It is headed "Startling Advance in the Cure of Disease—Medical Enthusiasm," and it is not till the eye reaches the bottom of the column that the abbreviation "[Advt.]" modestly suggests that all the wonderful things that have been related in the article are there for a specific purpose. The column is written on the best pattern of the *Times* advertising staff; a number of vapid generalities about the advances in medicine; the ailments that flesh is heir to, and the scientific treatment of disease, are given forth with an air of authority as transparent as it is offensive, when the real object of it all is considered. A treatment, inexpensive and suitable for home application, has been brought out and received the approval of the medical profession, not only in Great Britain, but also all over the Continent, so that it has resulted in "practically universal adoption." Now stuff of this kind should carry its own condemnation with it. If the treatment "may be undertaken in the patient's own home with almost the certainty of a cure, even in the most obstinate cases," what is the use of an "Institute"? Moreover, if the treatment has resulted in "practically universal adoption," what need is there to advertise it and to have a special "Institute," run for the benefit of the advertisers, to carry out what is "practically universally adopted"? We do not know whether the lack of inventiveness of advertisement writers, the want of intelligence of the public, the rapacity of newspaper owners for advertisements, or the greed of quacks is suggested to us most strongly by such poor, sorry nonsense as this. But the points in the advertisement that we object to most strongly are the offensive suggestions that this precious treatment is hailed with enthusiasm by the medical profession, and the way in which an honoured name such as that of Sir J. Crichton-Browne is dragged in. We have no hesitation in saying that such an advertisement is as lacking in good taste as it is in good sense, and that the *Standard* has cause to blush for the great traditions of the past when it inserts stuff like this to read as ordinary newspaper matter.

Liability for Infection.

A CASE fraught with a most important issue to medical men was decided last week in the Court of Appeal. The facts have been already mentioned in THE MEDICAL PRESS AND CIRCULAR, but in view of the appeal, full comment could not be made. The plaintiffs were an auctioneer and his wife, a Mr. and Mrs. Crier, who sued Drs. Currie and Hope, medical practitioners in partnership at Ealing, for damages on the ground that Dr. Currie had infected Mrs. Crier with scarlet fever while attending her in her confinement. The facts that Dr. Currie had seen a scarlet fever patient before attending Mrs. Crier, and that Mrs. Crier had contracted scarlet fever were not in dispute; the point was, did Dr. Currie infect her, and if so, did he do so negligently? At the trial the jury found that Dr Currie had taken all the precautions usually considered necessary between visiting the scarlet fever patient and attending Mrs. Crier, and this verdict, we are glad to see, was upheld in the Court of Appeal. Every medical man in general practice has his life worried by the question as to how far he is likely to carry infection from some source or another to his confinement cases, and though it rarely happens, it is inevitable that in the absence of full knowledge of prophylaxis and through lack of opportunity to carry out every conceivable precaution, infection should be conveyed from time to time. The world would not be human if certainty were attainable. It is, then, comforting to know that it will be held sufficient protection for a doctor if he takes all reasonable precautions in the matter of disinfection. Clearly it is not always possible

in the rush and hurry of practice to take all ideal precautions. In other words, all that is expected of a doctor is that he should do his best, as Dr. Currie did in the case in question, and that the risk, infinitesimal as it is, belongs to the patient, and must be taken by him or her as risks are taken in everyday life. We congratulate Dr. Currie on successfully vindicating not only himself, but his profession. Any other decision would have pointed to the necessity of one set of general practitioners to attend fevers and another to conduct midwifery cases!

Manchester Food Inspection.

THE way in which commercial interests unblushingly enter the lists against those of public health was forcibly illustrated last week—not at Chicago—but before a committee of the House of Commons. The occasion was the consideration of a Bill presented by the Local Government Board confirming a provisional order granting the Manchester Port sanitary authority power to inspect foodstuffs entering the port, and this necessary authority was vehemently opposed by the Manchester Ship Canal Directors on the ground that such inspection would place Manchester commercially at a disadvantage with Liverpool. It appears from the evidence that the Liverpool Port authority have not the power sought by Manchester, and it was argued on behalf of the Manchester Ship Canal that shippers would send their foodstuffs to Liverpool in preference to Manchester if inspection were known to take place at the latter port. Although it is to be hoped that Liverpool will immediately come into line in the matter, the action of Manchester suggests to us a deplorable cynicism with regard to the health of the country. We should hardly have expected a large commercial company publicly to object to food inspection on such absolutely unworthy grounds. We are glad to say that the Commons committee unanimously confirmed the order.

The British Medical Association and its Charter.

WE observe that the Council of the British Medical Association has decided to recommend that the proposed application of the Association for a Royal Charter be postponed for twelve months. In thus shelving the question we believe that the Association is acting wisely. There is no doubt that to many of the members it had not been made clear what advantages they would gain in lieu of the safeguards at present afforded them by the Companies Acts. As long as the Association remains a registered company, it is subject to the ordinary conditions of company law, and these conditions have as their object the protection of the property of the shareholders against a dominant clique or party. Some very strong reason would have to be brought forward to prevail upon members to throw away these safeguards, and we are bound to say that no such reason was made evident. As far as could be judged, the demand for a Royal Charter was merely the expression of the foolish vanity of a few people, who thought, without considering the question, that the importance and prestige of the Association would be enhanced by its possession.

PERSONAL.

AFTER due consideration of all the facts of the case, the Attorney-General has ordered a *nolle prosequi* to be entered with reference to Dr. George Robert Adcock, whose trial for the alleged manslaughter of Major Whyte, D.S.O., took place at the last sessions of the Central Criminal Court.

BY the election of Mr. Henry Morris as president of the Royal College of Surgeons, the Middlesex Hospital now has the honour of including on its staff the presidents of both the Royal Colleges of Medicine and of Surgeons.

WE regret to have to record the death of Mr. Edward Rawlings, one of the founders of the Royal National Fund for Nurses, and for many years one of its most active supporters.

IT is commonly reported that Sir William T. Collins is to be one of the members of the Royal Commission on Vivisection. Sir William's keen work on the Vaccination Commission during the seven years that it sat doubtless contributed to his selection.

We understand that Lord Selby, better known to the public as Mr. Gully, will be chairman of the Commission.

IT is announced that Dr. McKenzie Johnston has retired from his post as Surgeon to the Ear and Throat department at the Edinburgh Royal Infirmary. Many old Edinburgh men will hear the news with regret.

MR. W. L. SAUNDER, the secretary and general superintendent of the Manchester Royal Infirmary, who died early this month, had held his post for nearly thirty years.

AT the annual meeting of the Leeds Medico-Chirurgical Society. Dr. H. H. Bampton of Ilkley was elected president for the year.

DR. A. A. MARTIN of Eastbourne was the object of a savage attack by an insane patient in the street last week. Dr. Martin, who has recently received a commission in the volunteers, defended himself with great bravery and eventually overpowered his assailant.

THE news of the death of Dr. Mary Putnam Jacobi has just reached this country. As one of the pioneers of women's medical education, as professor for ten years in the Women's Medical College at New York, and as the wife of a distinguished husband, Dr. Mary Jacobi was well-known in many circles.

ON the occasion of his marriage a handsome presentation of silver plate has been made to Dr. John Mortimer by the staff of the Exeter Dental Hospital, an institution to which Dr. Mortimer is consulting physician.

DR. W. MUNCH will preside at the congress on child study to be held at Berlin early in October.

THE death of Dr. John W. Dodds of Cramlington village was found to have occurred through an overdose of belladonna accidentally taken.

A CLINICAL LECTURE
ON
CHRONIC RHEUMATISM AND RHEUMATOID ARTHRITIS.

By J. ODERY SYMES, M.D., D.P.H.
Assistant Physician and Bacteriologist, Bristol General Hospital.

IN no group of diseases is our nomenclature more confused than in the rheumatic group. Under the title of rheumatoid arthritis we have certainly two, and probably more than two, distinct diseases; whilst chronic rheumatism includes not only a fibrositis affecting muscles and the ligaments of joints, but also relapses from and sub-acute attacks of rheumatic fever, and any stiffening of or thickening in the joints which may follow rheumatic fever. Muscular rheumatism you are all familiar with in the common form of lumbago and torticollis, conditions not at all difficult of diagnosis. When, however, the muscles of the shoulder-joint are implicated (omodynia) it is often difficult to decide whether the pain lies in the articulation or in the overlying structures. This brings to us the question, "Is there a true chronic articular rheumatism?" If all cases of sub-acute rheumatism, all cases of gout, gonorrhœal rheumatism, and of rheumatoid arthritis are eliminated, joint conditions which can be styled chronic articular rheumatism will be very few, and personally I am inclined to doubt the existence of such a disease. Cases of chronic swelling, stiffness, and pain in the joints, following an acute febrile attack with arthritis, are in the majority of instances early types of rheumatoid arthritis, a fact which is unfortunately only too often overlooked. Spender defined rheumatoid arthritis as "a progressive degeneration of joints of a special kind, accompanied by atrophy of some structures and hypertrophy of others. The course of the disease is variable, but is ordinarily towards irrevocable damage and ruin of the structures involved." Obviously this definition might be made to include a number of widely different joint diseases, but we can clearly differentiate two varieties of rheumatoid arthritis, one (osteo-arthritis) in which proliferation of bone is a characteristic, and the other (fibro-arthritis) which is associated with increase of fibrous tissue in and around the joint. It is, however, unlikely that chronic rheumatism would be confounded with rheumatoid arthritis with well-marked bony and fibrous changes. It is only in the early stages or in very slight cases of rheumatoid arthritis that the mistake is likely to be made, and I purpose to day to indicate to you the points which should enable you to make a correct diagnosis. Looking first at the predisposing causes, you will find that the majority of cases of muscular and chronic rheumatism occur in adults, and more commonly in men than in women, whilst in rheumatoid arthritis the order of things is reversed. Pains in the limbs and joints in women at the climacteric, however, are mostly rheumatoid in nature. Sufferers from chronic rheumatism will frequently give a personal or family history of past rheumatic fever, of tonsillitis or of chorea, and the evidences of endocarditis will be detected by physical examination. Cases of rheumatoid arthritis associated with the rheumatic phenomena are on the other hand exceptional, but you will find this disease not infrequently dating from an accident, or injury, a confinement, an attack of epidemic disease such as influenza, or associated with some slight suppurative or ulcerative lesion. Anything, therefore, which permits of the possibility of a chronic pyæmia or toxæmia should lead you to suspect the presence of rheumatoid arthritis. The most frequent causes which are overlooked, especially among out-patients at the hospital, are endocervicitis and endometritis, foul conditions of the teeth and gums, suppuration in the accessory sinuses of the nose, and intestinal dyspepsia associated with constipation. The pains of both rheumatoid arthritis and chronic rheumatism are much influenced by changes in the weather, intensified by cold and damp, and relieved by warmth. Chronic rheumatism is the more readily relieved by change of locality, being favourably affected by removal to a dry, sunny, and bracing neighbourhood.

In the signs and symptoms of the disease there are to be found several distinctive features. A persistent pulse rate of from 90 to 100 without corresponding elevation of temperature; the presence of sweating on hands, feet, and face, or of deep pigmentation or freckling of the skin; exaggeration of tendon reflexes—all these are characteristic of rheumatoid arthritis; and the probability is increased if associated with the pains there be vaso-motor symptoms resembling those seen in Raynaud's disease, and if neuralgia be present, especially neuralgia extending up from the neck over the back of the head. The importance of looking for these signs lies in the fact that they can be detected before there are any definite changes to be found in the joints. Vague, indefinite pains in joints or limbs associated with several of the above mentioned symptoms should always be regarded as indicative of rheumatoid arthritis.

Symmetrical distribution of the joint lesions, especially if these are persistent, and if the smaller interphalangeal or metacarpo-phalangeal joints are involved, is suggestive of rheumatoid arthritis. It is, too, characteristic of this disease that the pain is often worse at night when the patient is in bed, and the sufferer in order to obtain relief feels that he must get his arms and hands from beneath the bed-clothes. In old people chronic rheumatism is often very intractable, invading fresh groups of muscles, and gradually spreading until the body feels as if it had been beaten all over. There is stiffness on waking in the morning which gradually improves as the day goes on, only, however, to return after the night's sleep. With this form of rheumatism there is an elevation of temperature of about a degree or a degree and a half, much constitutional disturbance, mental depression, and dyspepsia with flatulence and constipation. Such a condition may persist for weeks in spite of remedies. It is in these protracted cases in elderly people that you will find the nodules of white fibrous tissue which are characteristic of chronic rheumatism. They vary in size from a pea to an almond, and lie on or in the muscles. The skin over such nodules is not reddened, but they are tender on pressure. The fascia on the outer side of the thigh, the lumbar aponeurosis, the occipital and shoulder muscles are the most frequent sites of these nodules. Practically these nodes are not of great value from a diagnostic point of view, for they are only rarely present and require skilled manipulation for their detection. The masseur will frequently be able to find them when the physician cannot do so. Similar fibrous nodules I have seen in rheumatoid arthritis, but not lying in or on the muscles, but over the metacarpo-phalangeal joints or in tendon sheaths.

Vague pains in articulations flitting from joint to joint are suggestive of chronic rheumatism rather than rheumatoid arthritis, for in the latter disease the pain is persistent and does not show the same tendency to clear up quickly and pass to a fresh site. Rapid wasting of muscles with but slight sign of local disease is met with in rheumatoid arthritis, and is to be distinguished from the atrophy of muscles which comes on as a result of disease in severe cases of muscular

rheumatism. The former is partly due to spinal and peripheral nerve changes, and is much the more severe in character.

Subjective sensory symptoms of a peculiar character are very frequently met with in the early stages of rheumatoid arthritis. They are of different kinds. Thus there may be complaint of pain shooting from the ball of the thumb to the elbow, pins and needles in the extremities, a feeling as if the hands and arms had been plunged into cold water, numbness, weakness, a sensation of discomfort and restlessness in the limbs. All such are characteristic of rheumatoid arthritis, rather than of chronic rheumatism; indeed in the latter I have never met with such symptoms apart from neuritis.

I have now put before you the chief points that help us in the making a diagnosis between rheumatism and rheumatoid arthritis in the early stages. These remarks do not apply to the well-marked cases of fibro- or osteo-arthritis. In such no difficulty generally presents itself. But you cannot afford to wait for the establishment of such joint changes as will render your diagnosis certain, for if you do your treatment will be of little service to your patient, as it is pre-eminently in the initial stages of the disease that amelioration of the condition is to be expected. Rheumatisme fibreux is a form of chronic rheumatism affecting the palmar fascia and leading to Dupuytren's contraction. It is generally found in young girls and is associated with old-standing endocarditis. Rheumatoid arthritis is met with in children, and there is sometimes with it an enlargement of the spleen and of the lymph glands, signs which would sufficiently distinguish the condition from chronic rheumatism. It is sometimes said that the pains of chronic rheumatism are relieved by salicylate compounds, whilst those of rheumatoid arthritis are not. This, however, is not the case, for many sufferers from rheumatoid arthritis experience much relief whilst taking sodium salicylate or aspirin. The salicylates, it should be remembered, do not cure rheumatism either acute or chronic; they relieve pain and keep the morbid process in check; more than this should not be claimed for them. Chronic rheumatism has several distinctive complications, chief amongst which I should mention sciatica, tonsillitis, pharyngitis, rhinitis, and laryngitis. Iritis is frequently spoken of as rheumatic, but too much reliance cannot be placed on this symptom, for it is a not uncommon accompaniment of rheumatoid arthritis.

The importance of correctly diagnosing between these two diseases lies in the fact that they demand very different treatment. The administration of salicylates and the ordering of massage is the routine treatment of any kind of joint or muscle pain by a large number of practitioners. Under such a system it is found that many persons are made worse by the rubbing, and that when the salicyl compounds are withdrawn the pains immediately recur.

Treatment.—In general the indications for treatment in the two diseases are as follow:—Chronic rheumatism calls for an eliminant course of treatment, whilst rheumatoid arthritis is most benefited by the exhibition of tonics.

Thus we see that in chronic rheumatism the drugs employed are the salicylates, alkalis, guaiacum, sulphur, potassium iodide and ichthyol—drugs increasing the secretions of the bowel, skin, liver, and kidneys.

At the outset of an attack of muscular rheumatism, the patient should be given a dose of calomel (as Plummer's pill) and a smaller dose should be given every third and fourth succeeding night. The first acute pain may be relieved by fomentations, hot baths, or anodyne applications and by the administration of aspirin or sodium salicylate in full doses. If the pain recur each time the salicyl compound be withdrawn, then recourse should be had to one or other of the drugs before mentioned. A mixture which is very largely used in the outpatient department consists of tinct. colchici 10 minims, pot. iod. 3 grains, pot bicarb., 10 grains, tinct. guaiaci ammon. 15 minims. mucli. acacia q.s., aquam ad $\bar{3}$; this is rather a nauseous draught to take three or four times a day, and as an alternative I sometimes use the old pulv. guaiaci co. (Chelsea Pensioner) in 30-grain doses. It contains equal parts of guaiacum resin, precipitated sulphur, heavy magnesium carbonate, gum acacia, and potassium carbonate. Guaiacum resin may be administered as a tabloid or in cachet, but it is more effectual when combined with other eliminants such as sulphur. Doses of ten grains of sulphur and ten of guaiacium resin combined administered four times daily after meals are most efficient. Recently the oxybromides of some of the metals have been recommended for chronic articular pains, but I have found no benefit follow their use.

Side by side with the administration of drugs there must be an effort made to improve the condition of the muscles and to increase the eliminative powers of the skin. This is best done by a course of Turkish baths taken on alternate days and followed by good rubbing. Some patients state that they cannot take Turkish baths without feeling faint and giddy, and for these vapour baths or simple daily massage may be presented. The rubbing should be continued for at least three weeks, and the patient should be warned that the muscles may feel even more painful than formerly after the first two or three applications. If the rheumatism does not yield to this treatment, the high frequency current given on alternate days sometimes yields excellent results.

To complete convalescence a change of air to a dry warm mildly bracing climate is desirable, and the patient should be ordered to take moderate exercise such as golf, walking or riding.

It will be seen from the foregoing that the treatment of chronic rheumatism is tedious and trying to the patient, and for this reason the best results are, I think, obtained by residence at some home or foreign spa. In this country Harrogate, Llandrindod Wells, and Woodhall Spa are suitable places in the summer months, whilst during the colder months of winter and spring patients do best in a milder climate such as that of Clifton, Cheltenham, Bath.

Aix-les-Bains, Contrexeville, and Baden bear high repute for the treatment of chronic articular and muscular rheumatism.

Sufferers from chronic rheumatism should be warned against free indulgence in animal food, and their diet generally should be lighter than that of persons in good health. The occasional use of some alkaline table water should be recommended, and alcohol in any form forbidden. Moderate systematic exercise, frequent warm baths, and the wearing of warm clothing will lessen the risk of recurring attacks. Damp clay soils, absence of sunshine, sudden large variations of temperature, are all predisposing causes of chronic rheumatism and where possible the sufferer should reside so as to avoid these conditions.

I shall touch upon the treatment of rheumatoid arthritis only in so far as is necessary to point out the differences between the measures required for the successful treatment of this disease, and those which we have already considered. The one essential point in the treatment of rheumatoid arthritis is the discovery and removal of the primary focus of intoxication.

This intoxication may be bacterial in origin, or it may be the result of some error of metabolism, such as we associate with gout and arterio-sclerosis.

Unless this can be done all our efforts must be of a palliative nature, and aimed at the preservation of the general health of the patient until such a time as the poison shall have exhausted itself. A systematic examination of the patient should be made, the past history closely scrutinised, and every detail of the method of living ascertained. I would repeat that the conditions most commonly overlooked are septic conditions of the mouth, chronic inflammatory or suppurative lesions of the nose, throat or accessory sinuses; in women unhealthy states of the pelvic viscera, and

in both sexes persistent flatulent dyspepsia, more particularly associated with intestinal fermentation. If you glance through a list of drugs employed in the treatment of this disease, you cannot fail to be struck by the number of them which have a direct or indirect antiseptic action on the bowel contents, *e.g.*, creosote, guaiacol, guaiacol carbonate, salol, B. naphthol, sodium salicylates, methylene blue and iron. The success of the so-called Salisbury treatment depends in large part on the fact that by limiting the starch and sugar in the diet the fermentative changes are lessened, and the supply of the toxic material cut off. Chronic rheumatoid arthritis in elderly persons is often associated with arterio-sclerosis, the two conditions being alike excited by some error of metabolism. Once the source of infection is discovered and dealt with, the treatment of rheumatoid arthritis resolves itself into supporting and improving the general health by the administration of tonics, and by suitable climatic conditions, in restoring the mobility of the joints and improving the muscles by baths, rubbing, and exercises; and in regulating the diet and habit of living in such a way as to confer the greatest amount of benefit to the system generally, but more particularly upon the nervous system, on which the effect of the toxin is always so marked.

The point I wish to emphasise is this: that the treatment of chronic rheumatism is entirely different from that of rheumatoid arthritis. In the former an eliminant treatment is indicated, which if adopted in the case of the latter would only result in an aggravation of the disease; and whilst in chronic rheumatism the adoption of measures such as bathing and massage early in the disease is beneficial, in rheumatoid arthritis such procedures will in the early stages only tend to perpetuate and intensify the evil. There is one point I should like to mention to you in conclusion, namely, that however successful you may be in determining and removing the exciting cause of an attack of rheumatoid arthritis, you cannot hope, and you should not leave your patient to hope, that the old standing structural changes of osteo-arthritis with the resulting crippling can ever be repaired. Rheumatoid arthritis is not a disease from the treatment of which you may expect striking successful results ensuring the gratitude and admiration of your patients. You may check the progress of an old-standing case, but the structural changes and the personal discomfort remains, and if you are able to diagnose and successfully stop a case in the early stages the symptoms have probably been so slight that your patient is ignorant of the danger of life-long crippling from which he has escaped.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week's issue will be by Jonathan Hutchinson, LL.D., Oxon. and Cantab., Hon. M.D. Dub., F.R.C.S. Eng., F.R.S, Consulting Surgeon to the London Hospital, the Hospital for Diseases of the Skin and the Royal London Ophthalmic Hospital on "The Transmission of Syphilis to the Third Generation," delivered at the London Hospital, June 13th, 1906.*

ORIGINAL PAPERS.

A STUDY OF HYDATIDIFORM MOLE: WITH THE RECORDS OF THREE TYPICAL CASES.*

By JAMES OLIVER, M.D., F.R.S.EDIN., F.L.S.,

Physician to the Hospital for Women, London.

DR. OLIVER desired, before reading his paper, to say a word or two about the theories of menstruation. He thought there was abundant proof, both clinical and pathological, that there was no such thing as a *decidua reflexa*. With regard to menstruation the usually accepted view was the denudation theory, which he did not believe could be maintained. In cases of retained menstrual fluid there was a strong case made out against the denudation theory. If that theory held good under those circumstances, one could accept it for all cases. One knew that menstrual fluid went on accumulating in cases of imperforate hymen, and where the cervix had become occluded and the uterus might be so distended with menstrual fluid that the tension would force the fluid through into the peritoneal cavity. He had operated upon cases in which the fluid had been forced through the Fallopian tube into the peritoneal cavity. If the denudation theory held true, the menstrual fluid would not accumulate in those cases, because the actual pressure of the fluid in the uterus when it was present in such large quantity would arrest the extravasation of blood from the capillary vessels which had been ruptured.

Hydatidiform mole consists in a more or less complete degeneration of the verrucose surface of the chorion whereby many of its processes become converted into cyst-like bodies—bodies which vary in size from a barley-corn to a walnut, but are seldom larger. Some authorities believe the change to be of a myxomatous character, but its exact nature has not yet been determined.

It occurs independently of any uterine influence, and is solely attributable to some aberration on the part of the germ-plasm. This is very evident, since this aberrant product has been known to develop in a uterus concurrently with another but a well-endowed oosperm, an oosperm which attained maturity, and was eventually expelled as a fully developed and living child; two germinal elements, *i.e.*, had been fertilised simultaneously, but their potency being very different, one pursued an abnormal, whilst the other pursued a perfectly normal course. Moreover, I have myself observed that to all intents and purposes conception may as readily succeed this as any other kind of abortion, the resulting gestation proceeding uninterruptedly and being terminated quite naturally.

However the change which produces a vesicular mole may be induced, it begins to assert itself at an early stage in the evolution of the ovum, between the third and sixth weeks of pregnancy, whilst the allantois is still active and before any marked physiological differentiation in the chorionic villi has taken place; hence it seldom happens that even a semblance of an embryo is detected amongst the débris. Towards the end of the third week of gestation the allantois becomes vascular, and rapidly thereafter the vessels of this structure extend to and invade the villi of the chorion, so that during a very limited period of its existence the developing ovum is everywhere placental, and at this stage the embryo, without the interposition of any so-called decidua reflexa, is nourished by these vascular processes which absorb nutriment directly from the endometrium generally. As these vessels thrust themselves into the chorionic villi they are accompanied by a portion of the external or mesoblastic layer of the allantois, a gelatinous-like structure which serves not only to bind the villous contents together, but plays an important part in maintaining the well-being of the ovum whilst the latter is universally placental. During the sixth week of pregnancy differentiation of the villi is effected; those which are destined to participate in the formation of the placenta undergo a remarkable change, and increase greatly in size,

* Read before the British Gynæcological Society, July 12th, 1906.

whilst those involved in the remaining four-fifths of the chorion begin at the same time to atrophy and, gradually declining, all trace of their existence is soon lost. Until this stage is reached the allantois and chorion have continued to act and react harmoniously upon each other, but about this time it so behoves the chorion to bestow its energy upon the endometrium, stimulating and arousing in it such vigorous local growth as is necessary for the evolution of the placenta, that the allantois is required to assume a more passive *rôle*. This transition may, however, induce a perversion of the latter's function, and the chorion being thereby prejudicially influenced the allantoidal vessels may eventually become more or less completely obliterated, and thus there may result the mole we are now discussing. Although functionally deranged, some of the placental and even some of the non-placental villi may excite such reaction in the uterine wall that a more or less intimate union may be established between the embryonic and maternal tissues, and the morbid processes connected therewith may prove troublesome not only during gestation, but after abortion. It is these morbid processes which are accountable for the more frequent occurrence of chorionic epithelioma after this than any other kind of gestation.

Hydatidiform mole may be observed at any time during the reproductive life of the woman, extremely early as well as very late. It may occur in a woman who previously has given birth to mature and healthy children only, or in one who has never before been pregnant.

In its early days this disorder is characterised by symptoms and signs which are essentially those of an ordinary threatened abortion, but later it may present more and more the characters of "a missed," or, as I prefer to call it, "a postponed" abortion, and this it may virtually become, for this product of conception may be retained for many months. In one of the cases recorded in this paper it was detained in the uterus eleven months, but the most prolonged case of "postponed abortion" which has come under my immediate notice was one in which the embryo, perishing about the tenth week of gestation, was not expelled until about the middle of the thirteenth month. In hydatidiform mole there is invariably the history of a more or less prolonged period of amenorrhœa, succeeded by a greater or less amount of discharge of an irregular and hæmorrhagic character from the external genitals, a discharge which may in no respect differ from that observed in an ordinary case of threatened abortion. In the majority of cases it is the continuance of this discharge which causes the patient to seek advice. For six weeks or as many months complete amenorrhœa may have been noted. Now, although the determining cause of menstruation is still unknown, yet the fact that this function is held in abeyance in cases of intra-uterine death so long as the product of conception is retained in the uterus is deserving of more than passing notice. I have elsewhere ("A Study of Four Full-time Ectopic Pregnancies." *Edin. Med. Journ.*, 1898) remarked that in association with full-time ectopic pregnancy, the menstrual function tends as a rule to re-assert itself about six weeks after the death of the fœtus, even although the dead fœtus is still harboured in the mother's body. In cases of intra-uterine death we are therefore not justified in assuming that the suspension of menstruation is simply and solely due to the presence of a perished ovum in the uterus. Again, it cannot be attributed to the mere occupation of the uterus, for this organ may contain a foreign body, like an intra-uterine stem pessary, or it may become greatly distended by retained menstrual fluid and yet menstruation recur regularly. The derangement is most probably due to some disturbance in the metabolism of the uterus, for the abortive or aberrant product of conception attracts to itself and absorbs nutriment which is elaborated and practically secreted by the endometrium. The demand made thus upon the uterus is very different to that made by an ordinary neoplasm, and induces such an alteration in its physico-chemical state generally that not only is menstruation held in abeyance, but the irritability of the organ is so impaired that it may for an indefinite time tolerate the presence of a vesicular or fleshy mole in its cavity. Reverting after this slight digression to the symptoms again, it may be observed that more or less abdominal pain is commonly complained of in conjunction with an hydatidiform mole, but this evidently is seldom noted until the hæmorrhagic discharge from the genitals attracts attention. In the diagnosis of this derangement it will be remarked that the physical signs are not specifically helpful. In the early days these may merely indicate that we have to deal with utero-gestation, and later that we are confronted with intra-uterine death. It may occasionally happen that a vesicle or even some vesicles are detected hanging from the cervical canal, and the presence of such would be considered strong corroborative evidence of the existence of an hydatidiform mole. The uterus which contains a mole of this kind may appear to be larger or smaller than the suspected duration of the pregnancy would lead us to expect; when larger the increase in size is seldom so pronounced as to constitute a sign of any real diagnostic value; but a diminished size is a most important phenomenon, since it may arouse in us a suspicion of intra-uterine death. In almost all cases of early intra-uterine death the consistence of the uterus, as estimated by a careful bimanual examination, is very different to that of a normally progressing pregnancy, and a knowledge of this may aid us in differentiating an abnormal from a normal gestation. In the case of a vesicular mole the uterine tumour is usually somewhat doughy, and no definite portions of a fœtus can be felt; ballottement is not elicitable, and auscultation reveals nothing worthy of note. The breasts occasionally, but do not commonly, display appearances indicative of pregnancy, and it seldom happens that fluid is obtainable from them.

Case I.—Hydatidiform mole as a first pregnancy at the age of forty.—Alice W., æt. 40, and married five years, has had neither a child nor a miscarriage. The last menstruation occurred three months before this patient came under my care, and during the fourteen days preceding her visit to me she had noted almost every day a little blood-coloured discharge from the vagina. During the last three weeks she had complained of pain, somewhat severe, in the lower abdomen, especially the left half.

Physical signs.—"The abdomen is occupied centrally by a small globular swelling which arises in the pelvis, and extends to a spot located

midway between the pubes and umbilicus. It is everywhere rather tender to the touch. Auscultation reveals nothing. The breasts are merely full. The cervix uteri is located far back, and towards the left side. It is rather soft. The hypogastric swelling is the enlarged uterus; its consistence is of an indescribable character, and very different to that of an ordinary pregnancy." Twenty days after the aforesaid physical signs were recorded an hydatidiform mole, chiefly composed of very small vesicles was expelled without trouble.

Case II.—Hydatidiform mole in a multipara at the age of forty-seven.—Ellen G., æt. 47, and married twenty-five years, has had ten children. She has never had a miscarriage. The last child was born ten years ago. During the six months prior to coming under my care she had noted almost daily a slight hæmorrhagic discharge from the vagina, but for five months before this started there had been complete amenorrhœa. Until eleven months ago she had menstruated as usual, and quite regularly. During the last four months she had complained more or less constantly of abdominal pain; this has never, however, been severe.

Physical signs.—"The hypogastrium is occupied by a globular swelling the size of a large cocoa-nut. It appears to be somewhat cystic. The breasts have an appearance characteristic of pregnancy, and fluid is obtainable from both, but not readily. The cervix uteri is located centrally. It is soft, and the os, which is open, has a very membranous-like margin. The vaginal roof anteriorly is slightly depressed by a swelling which is a portion of the abdominal swelling, and the whole is the enlarged uterus." Nineteen days after the aforesaid signs were noted a vesicular mole, weighing three pounds, was expelled completely and naturally.

Case III.—Hydatidiform mole in a multipara at the age of twenty-five. Conception eleven months afterwards.—Annie T., æt. 25, and married seven years, is the mother of five children. She has never had a miscarriage. The last child was born 2½ years ago, and it was suckled sixteen months. During the three months previous to coming under my care patient had noted daily an hæmorrhagic discharge from the vagina, but prior to this menstruation had been in abeyance three months. From the time that she considered herself six weeks pregnant until the constant vaginal discharge was established, she was astonished to find that sexual congress always caused her to lose a little blood from the genitals. For the last three months she had complained more or less of pain in the lower abdomen, and this had generally been worse at night. There never had been any feeling of sickness.

Physical signs.—"The lower abdomen is occupied centrally by a globular swelling, which, arising in the pelvis, extends to a spot located immediately above the umbilicus. It is everywhere tender to the touch. Auscultation reveals nothing to note. The breasts are flabby; they present none of the appearances of pregnancy, and no fluid is obtainable from them. The cervix uteri is very soft, and the abdominal swelling is the enlarged uterus."

This case I considered one of ordinary pregnancy; but two days after the aforesaid signs were recorded a vesicular mole was expelled. and the practitioner who attended her informed me that there was a good deal of hæmorrhage and that he had to clear the uterus as some vesicles were apparently incorporated with the wall of the uterus. Eleven months after this abortion the patient became pregnant again, and in due course a well-developed and living child was born.

PAROXYSMAL HEADACHE.

By JOHN T. MACLACHLAN, M.D.,
Extra-Dispensary-Physician to the Glasgow Royal Infirmary.

The author took occasion (*a*) to point out that in paroxysmal headache there were two factors that had to be attended to if success were to be obtained in the treatment of this obstinate form of recurring headache, which embittered the lives of its victims, and these were the brain and the digestive tract, particularly the liver.

The disease, in his experience, was more frequently found in women than in men. One of its most characteristic features was the regularity or periodicity of the attacks. Some patients (in bad cases) might have a daily attack; but it was more common, in his experience, for the attack to recur every week, or two weeks, or monthly.

He had cases that had a severe attack every three months, and one that was only prostrated once a year. But the last-mentioned case used to have periodical attacks every few months. The headache is of intense character, especially affecting one or both eyes, so that patients frequently cannot see to read the papers; indeed, there is a certain amount of photophobia present. In every case, except one, that had come under his observation during the last few years bilious vomiting was present, and added to the general misery.

Many of the patients were poor eaters, and several were pale and half-starved-looking. One, who was so intensely afflicted, was afraid she might commit suicide during a severe attack. The disease was closely allied to epilepsy, and the treatment he adopted, with considerable success, was similar to that employed in epilepsy.

The earliest sign of an approaching attack seemed to be the passage of a large amount of clear urine, which was probably connected with spasm of the arterioles. Throbbing of the temporal arteries could be occasionally observed. Latterly there appeared a state of congestion of the brain and liver, and probably other organs.

Two different kinds of cause were competent to determine an attack. Mental disturbance, or undue brain worry or fag would do so. On the other hand, indigestible meals, particularly when fatty or greasy articles of diet were partaken of, would start a seizure.

The principles of treatment, therefore, consisted in administering suitable sedatives to soothe the irritable brain, and to stimulate the liver; constipation, from defective secretion of bile, being generally present. He prescribed:—

R Potas. bromid., ½ oz.—6 drms.;
Potas. bicarb., ½ oz.;
Ik. aurantii, ½ oz.;
Aq., 8 oz.;
Sig.: ½ ounce after meals, in water.

and a liver pill containing vegetable laxatives, as in the well-known laxative vegetable tabloid of Messrs. Borroughs Wellcome and Co. One of them to be taken daily. When the headaches

(*a*) These remarks have been amplified before going to press.

cease to be troublesome, a course of nerve-tonics may be advantageously prescribed, especially the compound syrup of the hypophosphites. These remedies should be persevered with for a long time. The dietetic treatment was important. Most of the patients said they could not take milk or eggs. Ordinary cooked porridge soured in their stomachs. Then stews or broth were not tolerated well. There was certainly in many of those patients a faulty digestion of fats chiefly, and in a lesser degree carbohydrates. A light proteid diet was most suitable, avoiding frying as a mode of cooking. Thus, poached whites of eggs, boiled or grilled white fish, such as sole, whiting, flounder and haddock, boiled fowls, tripe, potted head, with well-baked bread and boiled rice were all suitable. Potatoes and all underground vegetables should be avoided, while tenderly-boiled green vegetables including cauliflower. were suitable and desirable additions to the dietary. Milk, which has no equal for nourishing a patient, as already stated, the patients did not find agree with them. But that difficulty was overcome by prescribing a small quantity of milk—one or two ounces—with hot water, and some bicarbonate of soda added to it. Gradually the quantity of milk could be increased until three or four tumblersful of milk were taken daily.

By the above treatment, patients were brought back to health; their headaches became tolerable and at distant intervals, and life once again became worth living.

CLINICAL RECORDS.

A CASE OF HYDATIDIFORM MOLE.

By J. MACNAUGHTON-JONES, M.D.

PATIENT, æt. 20, consulted me for metrorrhagia. She had been married eighteen months and was delivered of a still-born child at full period. She thought she had been pregnant some four months, but had a coloured discharge for some time. A few days after I saw her the hæmorrhage increased, and it was decided to empty the uterus. The mole shown * was removed, and the uterus was freely curetted, and then irrigated with weak formalin; a drain of sterilised gauze was left in and removed at the usual time.

Dr. Lockyer's report is as follows:—"This specimen shows (1) maternal decidual tissue which is very degenerate; (2) fœtal chorionic villi. The latter present marked hyperplasia of the cells of Langhan's layer, together with an abundance of syncytial buds. No large chorionic vesicles are present."

I had advised re-curettage of the womb after the next catamenial period. Seeing the nature of the pathological report, I was confirmed in the decision, and accordingly, two months after the first operation, I re-curetted the womb. Dr. Cuthbert Lockyer reported on the curettings:—"Inflammatory fibrosis has occurred in the stroma. The gland-tubules are small and show commencing atrophy. There is no sign of malignancy."

Being anxious as to the future of the case, I sent the reports to Dr. Teacher, of Glasgow, with a request for his opinion as to malignancy. He replied:—"I have examined Dr. Lockyer's slide, and I agree with him as to there being degenerated decidua and chorionic villi which show marked proliferation of the epithelium; but I would add that there is nothing in the proliferation to lead one to diagnosis of malignant disease. I have seen it quite as marked in an ovum of similar age in regard to which no such question arose. In the second place, the result of your curetting six weeks later is to my mind entirely satisfactory, and quite justifies your favourable prognosis. Moreover, the question of malignancy having arisen, whether on the clinical or pathological grounds, I think you were well advised in doing the curettement. I lately saw another chorion-epithelioma, which escaped diagnosis until too late, the symptoms having been very misleading and the onset insidious."

My object in bringing the case before the Society is to insist on the necessity of the careful examination of every suspicious mole and the prudence as a precautionary step of a subsequent curettage.

* Specimen shown and notes read before the British Gynæcological Society, July 12, 1906.

THE OUT-PATIENTS' ROOM.

HERPES AS A COMPLICATION OF A SYPHILITIC CHANCRE OF PENIS.

By HENRI DARDENNE, M.D.EDIN., M.R.C.P.

On May 6th, 1906, among the out-patients of the French Hospital was a man, named A. S., by occupation a waiter, who consulted me for some pimples on his penis and swellings in his groins. On examination I found his inguinal glands enlarged, hard and indolent. On the dorsum of the penis, in the coronal fissure, were eight or ten small erosions, the size of a pin's head, and these were capped with a muco-purulent fluid. There was a good deal of œdema about the part, this extending for about one centimetre on each side of the lesion. Palpation did not convey to the fingers the characteristic cartilaginous hardness of the syphilitic chancre. It was massive and pitted slightly on pressure. It was, in fact, diffuse. It was a typical herpetic lesion. The slightest irritation with a caustic or any irritating lotion of sores in that locality can cause a great deal of œdema and hardness. There is, I must say, never developed by these means the characteristic induration of the hard chancre, and the glands when affected are never to the same extent and in the same manner as when a syphilitic chancre is present. On further examination of the penis, I detected in the left fossa of the frænum a small circular-like excoriation about 2 millimetres in diameter, which had up to now escaped the notice of the patient and which had never caused him any pain. On dipping the index finger and thumb, and raising the ulcer from the subjacent tissues a distinct induration could be felt exactly corresponding to the base of the ulcer. It was typical of a hard chancre. There was scarcely any secretion.

Syphilitic chancres in the fossæ of the frænum are generally small and heal more or less rapidly and the induration has to be felt carefully before it is detected. These are the chancres which very often escape the notice of the patient.

The history which the man gave was briefly this. He had suffered three times from pneumonia of the left lung when he was 17, 18, and 25 years old. Previous to this he never suffered from any venereal diseases, except with a somewhat similar affection as the present one when he was 15 years old. He had had connection on April 2nd, and on May 2nd and 3rd he had felt some burning pain in the region of the glans penis, and on examination he had noticed a few white pimples about the size of a pin's head, and these on the following day had ulcerated and discharged freely. He had not noticed the small sore which was in the region of the frænum, for it had caused him no pain whatever. He could not realise that such a small sore could possibly

be the source of any future trouble, and this is generally the mental characteristic of such patients.

I advised him to use warm local boracic baths for an hour in the morning and in the evening, in order to allay the great irritation, and gave him black wash and calomel as a topical application. I prescribed mercury internally, and the salt I used was the prot. iodide in doses of ¼ grain three times daily. Under this treatment the herpetic ulcers healed within two days and the chancre within a week. The induration had nearly disappeared, and the inguinal glands had much diminished in size.

On July 6th he developed a papular syphilide which though very discrete was all the same very typical. He also had some mucous patches on the tonsils and on the mucous membrane of the lower lip, and a few papular crusts on the scalp.

Remarks by Dr. Dardenne.—This was a clear case of herpes combined with a hard chancre, and judging from the aspect of the inguinal glands the chancre had most likely appeared a few days previous to the herpes. Still more difficult cases to diagnose are those where the hard chancre and the herpes occupy the same situation. As an example of this, I may quote the case of a man who came to me a year ago suffering from herpes, and saying that a fortnight before he had had the same thing near the frænum and that it had been rapidly cured by a white powder given to him by a chemist. His glands (inguinal) were very much enlarged, and I told him that it might have been quite a different affection, perhaps a syphilitic one. Within 40 days after seeing me he developed a copious pustular syphilide. He had refused to take any mercury.

Herpetic affections of the penis are very prevalent in rheumatic individuals, and rheumatism is a very common affection in this country. No wonder, then, that patients who have had a hard chancre suffer from herpes, the chancre having acted as an irritant cause in a rheumatic constitution. It is therefore most important to be able to differentiate between the two lesions, which most often coincide or follow each other.

1. In herpes the base is not indurated, or rarely so, as when the lesions have been irritated by caustics, and even then the induration is œdematous-like in nature and is more diffuse and does not present the cartilaginous hardness of the hard chancre, which itself varies, according to the size and situation of the sores.

2. The inguinal glands in herpes are not affected, or when so they are never to the same extent as in the hard chancre.

3. Polycyclism and microcyclism, — This is one of the most important diagnostic signs. The contour of a syphilitic chancre is either circular, ovoid, or crescentic and more or less regular. On examining with a pocket lens the contour of a herpetic lesion, it is found to be irregular and geographic like in outline and this as if several segments of a minute circumference had actually fused together (polycyclism). These segments are all parts of small circles (microcyclism), like what the segments of a pin's head would be. These two signs are pathognomonic of herpes and of herpes alone. The solitary lesion of a syphilitic chancre cannot obviously enough, give the aspect of a compound one as herpes does.

4. In herpes the lesions are very small erosions, multiple, irregular, disseminated. They are also more superficial, heal more rapidly and without having any induration.

5. They are recurrent affections, the same individual being affected several times, and the patients have often suffered from gout or rheumatism. In a word, they have an arthritic constitution.

Yet with all these distinguishing features there are some cases which cannot be positively diagnosed, and time alone can help one in separating one affection from the other. As an example of the great difficulty one at times encounters, I may cite the case of Fournier, who, being puzzled as to whether a lesion was one of herpes or syphilis, sent the patient with a line to the great Ricord, who, carefully examined him for an hour and then wrote a huge interrogation point on a white sheet of paper and addressed it back to Fournier.

OPERATING THEATRES.

KING'S COLLEGE HOSPITAL.

TREPHINING FOR DEPRESSED FRACTURE.—Mr. PEYTON BEALE operated on a boy, æt. about 10, who had been admitted in a comatose condition after falling a distance of 12 ft. down a lift shaft. Shortly after admission the patient's state was as follows: He lay quietly in bed "curled up," that is to say, with every joint flexed, he would just open his eyes when spoken to, the surface of the body was pale, no anæsthesia or paresis, *i.e.*, there was evidence of sensation and motion on applying the point of a pin to various portions of the skin, the pulse was somewhat quickened and feeble, respirations the same, pupils somewhat contracted, *i.e.*, not dilating in the dark, right smaller than the left, temperature subnormal on admission but gradually rising. The boy had vomited three or four times. On examining the head there was obviously a depressed fracture in the right temporal region; there was a small hæmatoma over this area and extending up to the vertex; no bruising and no external wound. As the boy did not materially improve after vomiting, and as obviously depressed bone was felt through the scalp, operation was at once performed. The head having been shaved, a large flap of scalp was turned up so as to exposethe temporal region, together with parts of the frontal parietal regions. It was then seen that there was (1) a fracture starting about the region of the ear running through the temporal bone upwards parallel to the coronal suture; (2) a fracture running backwards from the temporal bone and through the right parietal as far as the occipital if not beyond it. The whole of the squamous portion of the temporal and a considerable portion of the parietal adjoining it was depressed, and was pushed under the edges of the neighbouring bone for a distance of quite a quarter of an inch. A one-inch trephine was then placed at the angle where the vertical met the horizontal fracture, so as to include part of the depressed and part of the normal bone; the latter, of course, was cut through first, and by the introduction of an elevator the depressed bone was lifted up; portions of this were cut away with bone forceps. No pulsation could be observed beneath the dura mater. On passing a probe between the bone and the dura, the latter was found to be separated over a very large area and as far upwards as the longitudinal sinus. Some blood escaped, but there was evidently no active hæmorrhage going on from any of the meningeal arteries. A small incision was then made through the dura mater, and on introducing a probe into the space between it and the pia mater about two ounces of blood escaped, all dark in colour and some in clot. Soon after this the pupils were found to be less contracted; the patient was evidently more conscious, as a greater amount of anæsthetic was found necessary to keep him quiet. A small drainage tube was inserted through the incision in the dura mater and an incision was made in the scalp flap, thus allowing the tube to project through the scalp when the latter was fixed in position by sutures. Some gauze drains were inserted beneath the scalp and round the tube between some of the sutures and in the middle

line, where a separate incision was made for that purpose. It was considered advisable to put a drain here, as it was the upper limit of the hæmatoma beneath the scalp. Mr. Beale said that the boy was clearly suffering from severe symptoms of concussion, together with those of cerebral irritation. If left alone he would have expected symptoms of compression to come on gradually within the next two or three hours. The amount of separation of dura mater was, he thought, very noticeable; it seemed as if the dura had been stripped up by blood accumulating beneath it, and yet there was not sufficient blood to account for this; it must therefore have been stripped by the sudden impact of the boy's head against some hard substance during the fall. He remarked that it was unusual for a boy to fall any distance head first; if this did occur, it resulted in a fracture of the base of the skull. The damage described in the case he had just operated on was almost certainly caused by the boy's head striking some hard substance during his fall.

ROYAL EAR HOSPITAL.

OPERATION ON A NEGLECTED MASTOID.—Mr. MACLEOD YEARSLEY operated on a youth, æt. about 15, who had been admitted on the previous day. The patient complained of great pain in the left ear and in the left side of the neck. Owing to his nationality (alien Jew) a full history could not be elicited, but it was subsequently ascertained that he had undergone a radical mastoid operation at another hospital, but, owing to his inability to attend for dressing at the stipulated time, the after-treatment had been greatly neglected. On examination a small scar was seen behind the left ear in the centre of the line of which was an opening about the size of a lentil, from which was protruding a mass of hair and cheesy material. The posterior wall of the cartilaginous meatus was so greatly bulged forwards that it obliterated the lumen of the canal. The glands in the side of the neck were swollen and the patient's head was inclined to the left shoulder. The temperature was 99 on admission, but rose on the morning of the operation to 101.5. Chloroform was administered by Mr. J. H. Chaldecott, and an incision made in the line of the scar, opening a large bony cavity filled with a foul pultaceous mass, the stench from which was overpowering; the operation was proceeded with under frequent washings with peroxide of hydrogen. It was found that the whole middle ear and mastoid formed a shell of bone full of the foul material described. The cavity in the mastoid extended to the tip of the process, where it was on the verge of perforating into the digastric fossa. The lateral sinus was exposed for about an inch; its wall was rough and apparently eroded superficially. The sinus, however, contained fluid blood. The whole cavity was thoroughly cleansed, peroxide of hydrogen being largely used for that purpose. It was further found that the previous operator had neglected to form the usual flap from the cartilaginous meatus. This omission was rectified; the walls of the fistula left by the former operation were excised and the upper part of the wound was sutured. The middle ear and the part of the cavity were packed with iodoform gauze through the meatus, but, owing to the foul condition which had been met with, drainage was also provided for through the lower part of the wound. Mr. Yearsley pointed out that this case well illustrated the evils brought about by neglect of after-treatment in mastoid cases. The ordinary radical mastoid operation, he said, provided it was properly done and every discoverable focus of disease thoroughly eradicated, usually presented no after difficulties. It was, however, of the utmost importance, he considered, that the after-treatment should be systematically and carefully carried out. Many surgeons, he said, thought to reduce the time taken up in the healing process by carrying out the subsequent grafting experiments known as "Ballance's operation," but numerous operators were inclined to abandon that method and depend upon careful plugging and antiseptic treatment. Mr. Yearsley thought that the experience of other otologists would bear him out in saying that grafting gave at least as many failures as successes; for his part he did not practise it, and yet in his operations the process of healing rarely took more than six weeks. In his opinion the results of grafting did not justify the risks incurred by one or possibly more subsequent operations. Returning to the case under consideration, it was obvious, he said, that a delay of a very few hours would have resulted in disaster. Two of the most serious complications of mastoid disease were upon the point of occurring, namely, perforation through the digastric fossa and implication of the lateral sinus. The latter blood vessel was already exposed, and its wall roughened; perforation of the digastric fossa resulted in the condition known as Bezold's mastoiditis, in which pus from the mastoid finds its way into the deep parts of the cervical region. In such cases, the counter-opening has to be made in the neck in order to drain the cervical abscess thus formed. One of the reasons for the horrible condition in which this boy's ear had been found was undoubtedly, he said, due to the omission of the previous operator to make a meatal flap. In ordinary cases a properly fashioned flap is applied to the superior wall of the central cavity, and by this means not only is the cavity provided with a source of growing epithelium, but a better communication is established with the meatus. By omitting this important step in the operation a pocket had been naturally formed between the cartilaginous meatal wall and the bony cavity in which pus and *debris* could easily accumulate.

A WORKMAN has died of bubonic plague at Havre. It seems to have been an isolated case, and although it is not stated where he caught the disease, there have been no further attacks. It should be remembered that, whatever may be the case in other European States, the medical and police regulations in France and Germany are so stringent that there can be practically no danger of disease spreading to England.

THE foundation stone-laying ceremony in connection with the new Central Home attached to that splendid institution, the Birmingham Lying-in Charity, Loveday-street, immediately to the rear of the Birmingham General Hospital, was performed by Mrs. C. G. Beale, wife of Alderman Beale, on July 14th.

DR. JAMES STEWART, of Rickmansworth, whose death we recently announced, has left estate in the United Kingdom valued at £135,604 8s. 9d., with net personalty £134,043 10s. 4d. He left two-tenths of his estate (over £25,000) to the University of Melbourne, Victoria, for scholarships in anatomy, medicine, and surgery.

TRANSACTIONS OF SOCIETIES.

BRITISH GYNÆCOLOGICAL SOCIETY.

MEETING HELD THURSDAY, JULY 12th, 1906.

MR. BOWREMAN JESSETT, President, in the Chair.

DR. JERVOIS AARONS showed a modified hollow ring pessary filled with a mixture of gelatin and glycerin, which made it pliable and when in use became still more so. The central opening was very narrow. He devised this pessary four years ago, for two patients who had acute retroflexion with prolapsed ovaries, as none of the pessaries he tried gave relief. While wearing the pessaries the symptoms disappeared completely.

The PRESIDENT asked whether it was used for retroflexion or prolapsed ovary. He would also like to know whether Dr. Aarons had tried a pessary with a soft pad on the posterior limb. He (the President) had found this form of pessary very useful in retroversion, and the pad seemed to keep the fundus of the uterus in its place, which he would have thought the present one would not.

Dr. HEYWOOD SMITH considered the weight of the pessary a disadvantage. The central aperture was too small for the cervix to pass through, so that the uterus would ride higher, and in some cases prevent the replacement being maintained.

Dr. SMALLWOOD SAVAGE asked whether these pessaries were used in uncomplicated cases only, and also if the condition was cured by using this pessary.

Dr. AARONS, in reply, said he had used the pessary for four years. The patients never complained of the weight of the pessary. It was only where the cervix was small that the pessary was useful. He had tried the pessary mentioned by the President, but it had not given any relief. A pessary seldom cured retroflexion; it more often only relieved the symptoms. The pessaries had been used in married women only.

Dr. CHARLES MAUNSELL showed a series of specimens (1) The first, carcinoma of the cervix, removed by Wertheim's operation. The specimen comprised the uterus with the broad ligaments, ovaries, tubes and the upper third of the vagina, with the para-vaginal and para-cervical tissue removed in one mass. After removing the uterus he dissected out the glands from the pelvis, and as they were enlarged along the iliac vessels he followed them up as far as the kidney on each side. That course did not add more than a few minutes to the operation, as the glands were very easily found. He found the ureter readily by tilting forward the ovary out of the ovarian fossa, when the ureter appeared through the peritoneum and was easily reached. Though the glands were so enlarged he could not find any evidence of cancer in them. His patient had no leakage of urine until the tenth day. On the tenth day urine was passed by the vagina through a fistula, but by washing the bladder out regularly it healed up in a few weeks.

(2) The second specimen was one of carcinoma of the ovary removed from a girl, æt. 25, who complained of a swelling in her abdomen for five months. She was a thin girl, and one could distinctly feel and see the tumour in the right iliac fossa extending towards the middle line. When he opened the abdomen there was some ascites present; there were adhesions between the tumour and surrounding structures; also between the liver and the abdominal wall. As he did not consider the growth malignant, he did not remove the other ovary. He removed a small cyst from the left ovary, which was innocent. However, the patient is still under observation and examined every few months. Though she was operated upon in March, 1906, she had put on flesh and there had been no recurrence.

(3) The third specimen was a myoma of the cervix in a woman æt. 47. She had metrorrhagia severely for two years. She had spoken of it to her neighbours and had been told by them it was usual for women approaching the change of life to bleed like that. She was practically bloodless. On examination, a tumour was found attached to the cervix which bled profusely when touched, so that he had to plug the vagina and did not examine it again until he was ready to operate. On drawing the tumour out of the vagina he found it was held by a narrow pedicle, which he snipped through with scissors. There was no further hæmorrhage and the patient recovered.

(4) The next specimen was one of tubo-ovarian abscess, and salpingitis of the other side. The patient was a multipara, æt. 24. He removed the tumour on May 6th, 1905. She was well for some months, and then complained of a profuse discharge from the vagina, with great pain which began after January 1906. He then removed the uterus, which was in a state of chronic metritis with profuse suppuration. He desired to raise the question whether he ought not to have taken away the uterus when he removed the tubes. It became necessary to put her under a second operation before she was cured.

(5) The next specimen consisted of two large tubo-ovarian abscesses of gonorrhœal origin, which had burst, and there was general peritonitis. The patient was a young woman, æt. 23, married about one year. She had no children, and complained of discharge from the vagina and some pain in the pelvic region. Three days previously she was seized with violent pain in the abdomen, and before that she was supposed to be suffering from influenza. On the day he saw her she had an attack of severe pain. She was sent up by train a distance of some forty miles and on arrival she was collapsed. A provisional diagnosis was made of ruptured pelvic abscess. On opening the abdomen he found free pus and two tubo-ovarian abscesses. He made two incisions, one below the umbilicus, and one above, washed out the abdomen, and drained with gauze. She made an uninterrupted recovery, and to-day was well and healthy.

(6) The last specimens were two tubo-ovarian abscesses which had ruptured two days previously. He operated as in the former case, but the patient died a few days afterwards. He did not regard the abscesses as gonorrhœal.

Dr. MACAN asked whether, in the second case of tubo-ovarian abscess, there was general peritonitis, and if so how long had it existed, and what was the cause of death?

Dr. HEYWOOD SMITH asked, in regard to the case in which the uterus was subsequently removed because of purulent endometritis, whether the interior of the uterus was examined at the time of the first operation, and whether it would not have been better to have postponed the operation until the inflammatory condition had subsided. By doing so it was possible the uterus might have been saved.

Dr. HODGSON asked what means had been taken to prevent infection after removal of the myoma of cervix? He would like to know whether antiseptics had been applied to the stump.

Dr. MANSELL MOULLIN said it was most unusual for pyosalpinx to rupture. He had operated on many cases, and had seen many more, but had never come

across a case which ruptured spontaneously. The interesting point about the series of specimens was that there should have been two cases which ruptured spontaneously.

Dr. SWANTON said the suggestion as to the means of recognising the ureters was valuable. With regard to the question of draining, Dr. Maunsell said he made the opening above the umbilicus as well as the one below. He considered it would have been better to have made an opening in the flank and drain through.

Mr. HARRY OVERY said he had noticed in several cases that the leucocyte count was a valuable aid as to the condition of the tubes, that is to say whether pus formation was taking place. He had seen two *post mortems* in which general peritonitis followed the rupture of pyosalpinx during operation.

The PRESIDENT asked how long it took Dr. Maunsell to remove the uterus and the glands in the abdomen, also what determined his choice of the route he employed in preference to doing a vaginal hysterectomy. Looking at the specimen, it appeared to him (the President) to be one which might easily have been removed by the vagina. The disease seemed fairly limited, the os and uterus were mobile and could have been readily drawn down. Time was an element of great importance in those operations, and removal by the vaginal route could have been accomplished in from thirty to forty minutes. He would be glad to hear how long the operation occupied Dr. Maunsell. Another question was the urinary leakage which resulted. Was it from sloughing of the bladder or from damage to the ureter? He had done Wertheim's operation three times. In one case which he had described already, the ureter was surrounded by the disease, and in removing the disease he tore the ureter across. The patient lived, but had a uretero-vaginal fistula. Dr. Maunsell's plan for finding the ureters was a valuable one. The chief difficulty was tracing the ureters down into the bladder so as to push them away from the uterine tissues. The case in which there was rupture of the tube was a very interesting one. He had never seen a case in which a tube had ruptured spontaneously, but he had seen several cases of pyosalpinges, in which while removing the diseased tubes the tubes had broken down and burst into the peritoneum. As a rule very little injurious result followed. Personally, he objected to washing out the abdomen in such cases, for it dispersed the pus.

Dr. MAUNSELL, in reply to Dr. Macan, said that in the first case there seemed to be a double rupture. The first one occurred several days before he saw her, as she had very severe pain. On the day patient was seen by him (Dr. Maunsell) she had another severe attack of pain. It seemed to him at first that there had been some leakage and the formation of an abscess with adhesions and that the abscess secondarily ruptured the day she was seen by him. Immediately the peritoneum was opened pus welled up. In reply to Dr. Heywood Smith, no medication could have possibly cured that tubo-ovarian abscess. A microscopical examination had been made of the ovarian tumour. As to the use of antiseptics in the case of cervical myoma, he douched the vagina before removing it, and the only after treatment he adopted was plugging with iodoform gauze, which was left in for forty-eight hours. The patient had not had a bad symptom and was up in a few days. The President desired to know how long Wertheim's operation took him. Including stitching up the wound, the time occupied was a little short of two hours. In the first case of tubal abscess the diagnosis of ruptured pelvic abscess was made. In the second case his diagnosis had been ruptured appendix. The carcinoma of the ovary was primary, and the pathologist confirmed that view. The adhesions did not seem to have anything to do with the cancer, there was no enlargement of the liver, and the adhesions were fairly soft, he could not understand how the peritonitis had been caused. The girl had since put on weight immensely and looked and felt well. Mr. Overy's question was concerned with the leucocyte count. In neither of those cases had he (Dr. Maunsell) time for that. The President asked why he chose the abdominal route, and stated that the operation performed was not really Wertheim's. The operation he (Dr. Maunsell) performed was, according to the opinion of the Master of the Rotunda, who saw the operation, Wertheim's, and a complete one. He did not think there was much more cellular tissue in the pelvis than was present in that specimen. With regard to the choice of route, of course it was easy to be wise after the event, and as it turned out it would have been possible to remove that fairly well by the vaginal route, though when he saw the case and examined it, the carcinoma was spreading out from the cervix on to the vault of the vagina. It was more extensive-looking than appeared from the specimen shown. He certainly believed it was better to remove every case of cancer of the uterus by the suprapubic route. With regard to the urinary leakage which occurred in one case, he thought it fairly certain that it was from some sloughing of the bladder.

Dr. HEYWOOD SMITH said, in explanation, that Dr. Maunsell appeared to have slightly misunderstood his question. He (Dr. Smith) did not suppose that any treatment could have influenced the ovarian disease if both ovaries were in a suppurative condition.

Dr. MACNAUGHTON-JONES showed a specimen of "Hydatidiform Mole," and read the notes, which are published elsewhere in the present issue (see page 88).

Dr. JAMES OLIVER read a paper on "A Study of Hydatidiform Mole, with the records of three typical cases," which will be found elsewhere (see page 85.)

Dr. HEYWOOD SMITH asked whether Dr. Oliver did not think it possible that the degeneration of the chorionic villi began at an earlier period than he seemed to suggest. He thought it would be advisable to refer Dr. Macnaughton-Jones's specimen to a pathological committee, as it did not seem to possess the characteristics which one generally associated with hydatidiform mole. There seemed to be an enormous hypertrophy of endometrium, and perhaps under those conditions curettage was justifiable. The tissue removed seemed to be somewhat fragmentary. In the case of an ordinary vesicular mole there would be no justification in subjecting the patient to the extra risk of a subsequent curettage at all. It was very unusual, in his experience, to see a hydatidiform mole thrown out at such an early stage as in the present case. It was only a couple or three inches long. As Dr. Oliver had shown, those moles grew, and not until the mole became so large as to act like a foreign body did the uterus make an effort at expelling it.

Dr. AARONS asked what was the subsequent history of those cases which were mentioned by Dr. Oliver?

Dr. OLIVER said one might have natural conception afterwards, and that seemed to negative the necessity for curetting indiscriminately. Of course, according to the pathology of chorionic epithelioma, it would seem as if hydatidiform moles had a disposition to embed themselves in the uterus, and the question was whether mere curettage would be sufficient in view of the possibility of the cases becoming malignant later on.

Mr. SMALLWOOD SAVAGE said his reason for rising to speak was that he had had two cases of hydatidiform mole, which occurred at the end of the child-bearing period, and one would think it was due to some reduced resistance of the maternal tissue to the chorionic epithelium. With regard to the pathology of the condition, it would have been interesting to have heard from Dr. Oliver if the sections had shown an excess of Langhan's cells. He would have liked to have heard what Dr. Oliver thought of the pathological examination of those tumours. Personally, in spite of the microscopical examination, he (Mr. Savage) would not regard that as of any great value. He considered that the clinical symptoms were everything to go by, and that if any hæmorrhage occurred after the first curettage, vaginal hysterectomy should be performed. He thought Dr. Oliver was rather lucky in his cases, when one remembered how the hydati-

diform moles in his own cases ended. With regard to pain, he would not agree with the view mentioned by Dr. Swanton, that pain was caused by the growth of the chorionic villi extending on to the peritoneal surface. In destructive hydatidiform mole many cases had been described where the mole had extended on to the peritoneal surface, and the patients had probably died very soon afterwards. But probably one of the symptoms in a large hydatidiform mole in the uterus was pain, and that was due to the extending of the uterus into the surrounding regions.

Dr. HODGSON asked whether it was absolutely necessary that a woman should conceive in order to have those vesicular moles. He thought it possible that a woman had an unhealthy lining to her uterus, and at the time she conceived the tissue was excited by conception and the mole was either stimulated to grow or was cast off. He did not think it had been clearly established that conception was absolutely necessary as a condition for having those moles.

Dr. OLIVER, in reply to Dr. Heywood Smith, said he did not think it was possible to have any change in the villi earlier than the third week. In his paper he stated that the change most likely occurred between the third and the sixth week. He had no doubt that the condition was inherent in the oosperm, immediately the spermatozoon and the ovum coalesced. Immediately fecundation took place there was no doubt a tendency to produce a mole. But he did not think it was possible to detect the change until the vessels from the allantois thrust themselves into the villi, until the ovum was placental all over. In reply to Dr. Aarons, he said it was remarkable that the only case which had come under his notice in which there had been any trouble in removing hydatid mole was the one in which the patient became pregnant eleven months afterwards. In all the other cases which he had seen, the mole had been expelled easily, without trouble and there had been no adhesion to the uterine wall anywhere. But in that one to which he had referred the patient was æt. 25, and had had five children before becoming pregnant eleven months afterwards. The medical men who had had the cases under their care after he had seen them had written to say that there was no trouble, except in that particular case, and in that the medical attendant said he had emptied the uterus with his hand, and had to scrape the mole from the uterine wall. In answer to Dr. Swanton it was of course admitted that those cases were much more likely to give rise to a malignant condition than were others, but it seemed to him that there was no difference in the moles themselves. It was simply a question of degree. The morbid process extended through the uterine wall, and this established the condition of malignancy, just as in adenomatous degeneration of the lining of the uterus one got some cases in which the adenomatous growths tended to penetrate the wall of the uterus. It was in such the extent to which the uterine wall was invaded which constituted the malignancy, and it was the same with hydatid moles. Dr. Swanton drew attention to the question of pain. He (Dr. Oliver) could not explain the pain at all. Pain in those cases had always been a great enigma to him, because one found exactly the same kind of pain in early uterine death, where the ovum had perished at the sixth week, and yet was retained five, six, or ten months. In these cases there was more or less abdominal pain. He could not say that the abdominal pain was due to the attempt on the part of the uterus to expel the mole. With regard to age, it was true the condition appeared to be more common towards the end of the reproductive life of the woman. But one found it almost as commonly under 35 years of age. About three months ago he saw the condition in a woman æt. 24, who had been married only 18 months. With regard to Dr. Savage's case in which there was no amenorrhœa, it was difficult to understand how one could have a hydatid mole with no amenorrhœa at all, because the hæmorrhage undoubtedly came from the uterine vessels and there was not much enlargement of uterine vessels until the sixth week, that is until the chorionic villi began to irritate the uterine wall to such an extent that the vessels responded. It was very difficult to understand why there should be no amenorrhœa. He did not believe in the differentiation of moles at all; he believed all moles were very much alike; it was the question of the incorporation of the embryonic with the maternal tissues which constituted the malignant tendency. Microscopically there seemed to be no difference in them. Of course those which penetrated the uterine wall a little more deeply seemed to show a little cell infiltration, but that was merely an exaggerated condition, an exaggeration of the more simple condition. With regard to Dr. Hodgson's question about single women, he did not think it was possible for a hydatid mole to occur in a woman who had never had sexual intercourse, the mole was due to the fertilisation of the germ plasm, undoubtedly.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

GERMANY.

Berlin, July 22nd, 1906.

The *Zeitschrift fur Hygiene* 50-3 contains a paper on EXPERIMENTAL BACILLARY PNEUMONIA by Dr. J. Kokawa. Experiments made by the author led to the conclusion that the disease is set up by direct injection of the bacilli into the lungs, or the infection may pass by the air passages. Probably in the human subject the infection is usually brought about in the latter way. But a hæmatogenous infection is not excluded, as the excitors of the disease may readily pass by the blood channel from some primary centre of disease.

The encapsuled bacilli alone are only capable of setting up disease when they are very virulent or are in large quantities; otherwise, predisposing conditions are necessary, such as injury, or a chill, etc. These factors apparently play an important part in the bacillary pneumonia of man, as here the bacilli do not penetrate in such large quantities as in experiments on animals.

Bacilli in whatever way they are brought into the lungs, are admitted through the epithelium of the alveoli into the lymph channels. Through the lymph systems of the lobar and alveola septa they spread out into the whole organ. The bacilli so taken up, for the most part, die so long as the lung tissue is sound. Inflammations of the lungs are only set up when the bacilli, unusually virulent, are eliminated into the alveolar lumina. The bacilli are much more quickly taken up into the lymphatic system as charcoal pigment. The reason for this is perhaps partly the chemotactic action of the bacilli on leucocytes.

The histological changes of experimental bacillary pneumonia and pleuritis are characterised by features that have a close connection with the biological properties of the capsule bacilli. *i.e.*—by a relative copiousness of mucus and strong swelling of the vacuole structure of the cellular elements in the exudate.

The passage of bacilli, into the lung tissue through the wall of a bronchial tube has not been proved.

AUSTRIA.

Vienna, July 22nd 1906.

CARCINOMA AND THE RONTGEN RAYS.

RIEHL showed the members of the "K. K. Gesellschaft" two microscopic preparations that raised an important discussion on the Rontgen rays producing carcinoma.

The first specimen was an epithelial carcinoma arising from the epidermal layer, while the second specimen was a spindle-shaped sarcoma. Both of these

neoplasms were taken from the cheek only two centimetres apart: the former from the superficial layer, the latter from the deeper cutis; both had risen from the cicatrix of Rontgen ray burns which had been applied for lupus seven centimetres broad, eight years ago. Ulceration was produced by the rays which caused a telangiectasis to appear that extended from the eyelid to the mammilla. It cured the lupus at the time, but a new area of lupus appeared later in a different place. The two tumours shown had no constituent of lupus although they originated on the cicatrix of the original lupus.

He showed another case of lupus vulgaris, which involved the whole side of the neck and head as well as a third of the thorax.

On the right side of the neck was a carcinomatous tumour ten centimetres, movable and lupus infiltrated at the base.

The patient had been frequently treated with the rays without effect.

Ehrmann asked how he could eliminate a Lupo-epithelioma which frequently did occur, quite spontaneously in lupoid cases. He would not venture to contradict Riehl, but thought there was a great doubt in the matter.

Holzknecht questioned the correctness of carcinoma arising out of the ulceration from rays. According to Unna's experiments there is a possibility of such arising, but there is also a possibility of some of the neoplasmic cells remaining after the ulceration from the rays.

There is no testimony to prove in the neoplasms shown, nor is there any proof in the surrounding tissues that the Rontgen rays had effected; and if no transformation can be proved, how can we say the rays produced cancer? Again, we have no history of the amount of ray force applied, and as we have carcinoma arising out of lupus it is just possible the quantity of rays was too insignificant to destroy all the lupoid cells though it may have arrested their progress.

Nobl said the Rontgen rays have the power of producing an atypical epithelial growth not unlike that produced. It is also observed that small doses of the rays produce various complex reactions such as the form of xerodema pigmentosa of Kaposi which has a decided tendency to become carcinomatous.

INTRA LIGAMENTAL PREGNANCY.

Lindinthal exhibited a patient he had successfully operated on for a pregnancy that took place in the meso-salpinx and rectum. The diagnosis was intra-uterine pregnancy with ovarial cyst, as the tumour lay to the left side with the symptoms of pregnancy.

When the laparotomy was performed the uterus was found empty of a fœtus; but there was present great hypertrophy and a decidua 8 millimetres thick, with a fœtus in the mesorectal ligament 22 centimetres in length. There was no ovarian cyst present.

THYROID CELLS.

Konigstein demonstrated the different secreting powers of the epithelial cells in the thyroid gland. There are two different forms in the parenchyma of the gland, (*a*) the large polygnal cell with well defined walls that takes up eosin greedily; (*b*) the small shrunken cell that takes up the colouring matter very sparingly in masses and not diffused as in the polygnal. The large cells are found individually throughout the gland intensely coloured, at other times in groups which are usually near the periphery and mostly to be met with in adults. In many places these polygnal cells form follicules by their arrangement with lumen in which a small drop of the eosin may be seen secreted from the cells.

ELEPHANTIASIS LYMPHANGIECTODES.

Lehndorff showed a child 16 months, with elephantiasis cong. præputium. After a normal birth a painless swelling was observed over the genitals and penis; no tumour, no swelling at the inguinals, nor enlargement of vessels.

HUNGARY.

Budapest, July 22nd, 1906.

SURGICAL CUTFIT FOR FIRE COMPANIES.

TWENTY-FIVE leather cases, containing emergency medicines and surgical instruments, are to be furnished to every company in the Fire Department of Budapest. With these cases always available, any one with surgical knowledge present at a fire may treat wounds on the spot. It is possible, too, that instruction in first aid to the injured will soon be given to all firemen.

SUICIDE BY CARBOLIC ACID.

The use of carbolic acid is not a passing fad among suicides. It is an established custom, due primarily to the fact that the legitimate uses of the acid are so numerous that it is easy for almost any person to give a druggist a plausible reason for the purchase. Death by carbolic acid is death by torture, but the would-be-suicide who is in real earnest does not stop to bother himself about a few moments or a few hours of agony. The Apothecaries' Association here favours the passage of a new ordinance regulating the sale of poison, and the Council will do well to give the proposal careful consideration. It is said that the placing of restrictions upon the free sale of concentrated solutions will do much good, with little inconvenience to the public, inasmuch as the more diluted solutions are perfectly satisfactory for most legitimate uses. The concentrated solutions are fatal but the weaker solutions are much less dangerous. There is reason to believe that a properly framed ordinance would reduce the number of suicides.

In an able article on the

TREATMENT OF GASTRIC ULCER

Dr. Wagner says that it has been customary to keep patients on a milk diet at least four weeks, after a hæmorrhage from a gastric ulcer and to avoid all other, especially proteid foods. This, he thinks, is a mistake. He has often observed the good effects of proteids in the hyperacidity of chlorotic girls without ulcer, and was led to try the same diet in ulcer, arguing that albumen binds the free hydrochloric acid, which keeps up the irritation better than any other food. The patients are often in a condition of chronic inanition; to begin with rectal enemata and small amounts of milk would be to keep up the starvation and thus prolong the healing of the ulcer, while large quantities of milk sufficient to meet the demands of the system would be risky. The treatment as practised by the author is as follows: Absolute rest for at least four weeks, icebag to the epigastrium. On the day of hæmorrhage 200 to 300 ccm. of iced milk and 1-3 fresh raw eggs are given, together with two grams of bismuth three times a day. By the end of the first week, the milk has been increased to 800 ccm. and the eggs to six to eight a day. Raw, scraped meat is allowed after the sixth day and after two weeks boiled rice or farina and zwieback. In three to four weeks a carefully selected mixed diet is well borne. The amount of bismuth is reduced considerably after ten days and at the same time iron in the form of Blaud's pills or with arsenic is begun. As compared with the milk diet, recurrent hæmorrhages are less frequent and the gastric pains are alleviated more readily and the general condition improves quickly. A large number of the patients were again seen a year after the treatment; the majority had experienced no further trouble.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

BELFAST.

ADDRESS AND PRESENTATION TO DR. DARNELL.—At a meeting held in the Medical Institute, Belfast, on the evening of the 17th inst., Dr. C. K. Darnell, of Bangor, co. Down, was the recipient of an address, a presentation of silver plate and a cheque for three hundred guineas from a large number of his medical brethren. On the motion of Prof. Symington the

chair was taken by Dr. J. Walton Browne, and letters of apology were read by Dr. Houston from the following:—Sir Wm. Whitla, Prof. Byers, Dr. Jefferson (Lisburn), Dr. Killen (Larne), Dr. Rowan (Gargary, co. Down), Dr. Warnock (Donegal), Dr. H. Buchanan Murray, Dr. Chas, C. Cathcart, Dr. J. S. Morrow, and Dr. Joseph Nelson (Belfast).—The Chairman briefly alluded to the circumstances which led to their meeting that evening, and spoke of the trying time through which Dr. Darnell had passed, and the universal sympathy felt for him by his medical brethren. Now this trouble was ended he hoped many happy years were in store for him and Mrs. Darnell. He then called upon Dr. Wm. Calwell, President of the Ulster Medical Society, who conveyed to Dr. Darnell the deep and warm sympathy, not only of the members of his Society, but also of numerous medical men throughout the United Kingdom who had joined in the presentation. In his capacity as one of the treasurers of the fund he had received letters from all quarters expressing hearty sympathy with Dr. Darnell, and often the wish that the case could be fought further. He claimed for Dr. Darnell that he had "exercised a reasonable degree of care and skill," also honesty of purpose and uprightness of conduct, which seemed to his professional brethren to entitle him to a verdict. It was only the absolutely prohibitive expense that prevented the case from being carried to the House of Lords.—Dr. Cecil Shaw, Hon. Sec. of the Ulster Branch of the British Medical Association, also read an address to Dr. Darnell, expressive of sympathy in the anxious and harassing experiences through which he had recently passed, and as a token of the friendship and sympathy of its members, they begged his acceptance of the accompanying cheque and piece of plate. The Chairman then handed to Dr. Darnell with the address a pair of solid silver candelabra, and a cheque for three hundred guineas, to which Dr. Darnell replied as follows:—"Mr. Chairman and Gentlemen,—Your truly kind address and generous presentation have been to me a matter of deep personal and professional satisfaction. It is particularly gratifying to me to know that you have recognised the justice of my contention in the recent prolonged lawsuit. I cannot imagine a more satisfactory or decisive pronouncement on a subject which touches the reputation of a brother than this professional assurance of yours. To enjoy the confidence and esteem of my patients and friends is to me a most pleasing reflection, and to receive the endorsement of their good opinion by my professional brethren is an honour and a privilege of which I may well feel justly proud." To the formal reply Dr. Darnell added a few words of thanks, not only for the substantial help that had been given him that evening, but also for the great kindness and sympathy he had received during the past two years, and without which he felt he could hardly have got through that time. On the motion of Dr. John Campbell, a vote of thanks was passed to the Chairman, and the meeting terminated.

COUNTY ANTRIM INFIRMARY.—The annual report of this institution, just issued shows an increase of work and a decrease of funds. The patients treated in the wards numbered 338, with a daily average of 33·74. The annual expenditure per patient for food was £11 12s. 10d., and for drugs and dressings £4 17s. 7d. The operations performed numbered 118, and the accidents treated were 293. Dr. St. George gives the record of an excellent year's work.

UNSOUND PORK.—Apparently the Chicago scandals have stirred up our local authorities to renewed vigour in the inspection of meat, a very desirable result. Last week the carcases of six pigs were seized and condemned as unfit for food, owing to tubercular deposits. It turned out that they came from the Downpatrick Asylum, and the authorities there, while giving every assistance at the inquiry, said that they slaughtered about one hundred pigs annually, and these were the first ever condemned, or even complained of. Some discussion took place in the Magistrates' Court on the appearances which would lead to an order for the destruction of the carcases. In these cases the disease appeared only in the necks, while the viscera appeared to be quite healthy. The presiding Magistrate said he knew it was a disputed point, but he did not intend to experiment on the inhabitants of Belfast, and ordered the destruction of the doubtful carcases.

INFANTILE MORTALITY: ADDRESS BY PROFESSOR BYERS.—At the annual meeting of the Bangor Nursing Society, held last week, an address on Infantile Mortality was delivered by Prof. Byers. After some general observations and some statistics, showing the importance of the subject Dr. Byers pointed out that as a whole infantile mortality had remained stationary of late years, while the death-rate generally had declined. From observations on those in a fair state of comfort and of intelligence, we might conclude that the normal rate for infants under one year old should be about 75 per 1,000, though from what is occurring in France, where great attention is being devoted to the subject, we may consider even that too high. There was no difficulty in showing that the question was essentially one of feeding. The lecturer put this in various ways, but perhaps the most striking to his lay audience was the observation of Newsholme, that it was twice as dangerous to feed an infant on condensed milk as on fresh cows' milk, fifty times as dangerous to feed an infant on cows' milk as on breast milk, and one hundred times more dangerous to feed it on condensed milk than on breast milk. Various schemes for educating and helping the mothers were described, and their results given, Huddersfield and Glasgow being specially recommended.

COUNTY ANTRIM ASSIZES: GRAND JURY.—No less than five medical men have been summoned to the Grand Jury at the present Assizes in Belfast. They are Drs. O'Neill, Dempsey, McKisack, Kirk, and Williamson. Happily for them, they are not likely to have to devote much time to their duties this sitting, as the calendar is a light one.

LETTERS TO THE EDITOR.

THE CHRISTIAN SCIENCE TRIAL.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—This case having terminated in what lawyers call a *nolle prosequi*, and your correspondent "Common Law" having kindly favoured us with an exposition of the law as far as it is definite on the question, perhaps you will allow me a statement that I was restrained from offering in my previous letter. It appears to me that some confusion has arisen in the public mind from which lawyers have not altogether escaped infection, otherwise the case would not have proceeded beyond the inquest, and that is that the public have come to regard "Christian Science" as though it were a form of quackery in medicine, whereas on the contrary it is simply as "Common Law" points out a religious ceremony or rite. There is, of course, nothing illegal in the exercise of such rite, consequently Dr. Adcock, I presume would not be responsible for not providing the deceased with legal medical attendance and having done nothing to accelerate death could not be liable in criminal law. In one word he has been in the position of a person falsely charged of committing a crime.

The confusion to which I refer, I should say, arises from the adoption of the absurd name of "Christian Science," which has not unnaturally generated the idea that something appertaining to the charlatan's treatment of disease is necessarily involved, but this is not the case, and so far from being so the defendant was taunted by counsel for departing from his recognised tenets and applying an antiseptic dressing, but I do not think counsel could make much of this, it being an ordinary precaution of cleanliness and such an one as any person might adopt where no sickness was concerned, as for instance, in spraying a room with Sanitas or Condy's Fluid, in order to freshen the atmosphere.

A second case of re-trial having just been recorded in another instance of death, the jury disagreeing, fills

one with confidence in this regard; it shows that the difficulty a jury sometimes experiences in decision, warrants the inference that every care is taken to sift the evidence—and to deal justly with all.

I am, Sir, yours truly,
CLEMENT H. SERS.

Brighton, July 20th, 1906.

SHODDY LEARNED TITLES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The letter from "Ethics" in your issue of July 18th is calculated to make us blush for our profession. When your original annotation told us that certain ambulance students had affixed the letters M.B., B.A., after their names on the strength of some grotesque denotation of their membership of St. John Ambulance Association, one was moved to contemptuous amusement at the inherent snobbishness of mankind. But now it appears from "Ethics'" letter, that the offender was a qualified medical man. That is another matter. We are entitled to demand investigation of the matter by the Defence Societies and by the General Medical Council. The latter body has shown itself in times past keen enough to prosecute medical men for using reputable American degrees to which they were legally entitled. What has the Council to say now to a medical man who deliberately misleads the public by an absolutely false suggestion that he is entitled to the degrees of M.B., B.A.?

Let us hope, Sir, for the honour of our profession, that there is some mistake somewhere, and that no medical *confrere* could have stooped to so discreditable an act. From your correspondent's letter I see that the tricky letters F.R.G.S. are said to have been also added. If there be one inexcusably mean thing more than another it is to add the letters F.R.G.S. to a medical title, when it is clear that the public must inevitably confuse them with F.R.C.S. Any self-respecting medical man would avoid using the title as he would shun the devil—unless, indeed, he happened to be in fact a distinguished geographer, which the majority of those holding the Royal Geographical Society's fellowship are probably not.

What have the St. John Ambulance authorities to say.?

I am, Sir, yours truly.
Clapham, July 20th, 1906. F.R.C.S.

SPECIAL ARTICLES.

MEDICAL INSPECTION OF SCHOOL CHILDREN.

REPLYING to the Medical Deputation which waited upon him on July 16th, to urge the necessity of systematic inspection of school children, the Minister of Education gave little hope that provision for this could be included in the new Education Act; but it is gratifying to note that in the debate upon the bill on the same evening expressions of opinion from all sides of the House were so unanimous and emphatic that the Government in the end agreed to amend the Act by addition of the following Clause: "It shall be the duty of every local authority to provide for the medical inspection of every child on its application for admission to a public elementary school, and on such other occasions as the Board of Education may direct, or the local education authority may think fit." In view of the fact that this addition to the Act, although it will no doubt disclose the amount of existing illness and physical disability, will make no provision for treatment of delicate children, it is difficult to understand the optimistic expression of opinion which Mr. Birrell put forth to the deputation, even before the amendment afterwards agreed upon had been proposed, He said that in this matter we should soon have caught up any foreign country and in future we should lead the way. He gave not the least hint as to the means, methods or machinery by which this desirable consummation was to be brought about, nor did he throw any light whatever upon it in his speeches later in the House of Commons. Certainly at present they manage these things so very much better in Germany that we shall at first, whatever energy be displayed be conducting the proverbial stern chase, which is always a long one. Not only have they in Germany for years practised the most systematic and complete inspection of school children, but they have organised the ways and means of dealing with the cases which call for medical supervision and treatment. In the matter of the physical development of the children, in every fundamental question touching the public health, in all the practical details of sanitary administration throughout, the Germans are advancing if not by leaps and bounds at least steadily and with sure footsteps to the front. Germany is presenting an elaborate object lesson in the fact that a bureaucracy of first-rate quality, guided from the centre by the best scientific advice and directing a well-educated and therefore in such matters a docile people can produce results much better than is possible with free democratic local governing bodies such as we rely upon in this country. Such bodies can act with wisdom only when made up of a fair proportion of what is wisest and best among the citizens; when dominated by what is most ignorant and most selfish the results, if not farcical, are too often tragic. Of this latter fact the last illustration was afforded by the exposure of the working of the now superseded Merthyr Tydvil Urban Council of which we lately gave an account. This Council had the reputation of being the worst in the three kingdoms; but many more sanitary authorities occupy positions not much below that bad eminence. Medical officers of health and sanitary inspectors are the servants of the local authority and in most cases are absolutely powerless to do more than carry out the orders of their masters without protest or complaint. This will be the position of medical school inspectors if such be appointed, for be it remembered that even medical officers are at present not employed by large numbers of authorities. In Germany not only have they practically banished small-pox by enforcement of vaccination and re-vaccination, which are ensured by surveillance of school children, but they are checking measles and scarlet fever and are raising the standard of health all along the line by attention to minor ailments and disabilities. Ears, eyes, and throats are systematically examined and children with defects in these regions are, when necessary, classed apart and separately dealt with. Dull and backward children, those of low intellectual capacity are also specially considered. Directly and indirectly in the matters of clothing and cleanliness much is effected; bathing by means of inexpensive douching and soaping is now practised at most schools, whilst hair is kept short and heads kept clean; and no one thinks of resenting the regulation by authority of such small but important items which contributes towards the welfare of the whole community. Here at home our people largely prefer to remain free and dirty, and our working classes are certainly among the least well tubbed in Europe. They have not been taught like the Germans to wash their bodies while young, and find it impossible to acquire a taste for personal ablutions in after life. All our public baths, however cheap and accessible, are failures as regards the great mass of the poorer classes; and as these classes have no facilities for bathing in their crowded homes, it is obvious they must in the main go unwashed.

THE MANAGEMENT AND CONTROL OF LUNATIC ASYLUMS IN IRELAND.

FOR some time past the medical profession and the general public have been interested in a dispute which has raged between the committees of various lunatic asylums throughout Ireland and the Local Government Board with reference to an Order issued by the

latter body and known as the "Public Bodies Order." In this dispute, the superintendents of the Asylums for some time sided with their respective committees, because it appeared that in various particulars the Local Government Board were striving to cast unnecessary duties of an absurd and onerous nature on the superintendents, and also to interfere in a somewhat arbitrary manner with the financial affairs of the asylums. The committee which took the most active part in thus contesting the order of the Board was that of the Richmond Asylum in Dublin. Into the rights and wrongs of their action in this matter, it is not our present intention to enter, as from a medical standpoint they are not of so great importance as are the sequelæ of the primary position assumed by the committee. It is sufficient to say that in the defence of that position the Committee had the complete support of their medical superintendent—Dr. Connolly Norman. The sequelæ are, however, of the most widely reaching importance not alone to the resident superintendents of asylums throughout Ireland and the medical profession generally, but also to that large section of the public who desire that the control of the feeble-minded should be in such hands that advances in the treatment of mental disease may result and not retrogression.

The dispute between the Richmond Asylum Committee and the Local Government Board ended when a mandamus was obtained by the latter body compelling the committee of management to fall in with the terms of the Public Bodies Order. This mandamus was not resisted by the committee, because, according to the committee's version of the matter, the Local Government Board made certain concessions to them. It was alleged that one of these concessions empowered the Committee to delegate to other officers certain duties which had been up to that time in the hands of the medical superintendents. The letter supposed to contain these concessions was not made public at the time by the committee, but subsequently a portion of it found its way into print, and it was then found to state in the clearest manner that "the intention of Parliament was to render the medical superintendent responsible for the entire management of his particular institution, subject, of course, to the superior control of his committee and other duly constituted authority. It rests with the resident medical superintendent, therefore, to permit books and documents to be prepared, verified, and kept by subordinate officers, subject to his supervision and control. He cannot, however, be permitted to divest himself of the responsibility for seeing that they discharge these duties in a satisfactory manner." It thus appears that in the most definite manner the Local Government Board refused to grant the so-called concession empowering the Committee to delegate the duties of the medical superintendent to other officers.

The sequelæ of the events we have thus briefly related may be said to commence from this point, and we shall relate them equally briefly. The Committee of the asylum keeping up still their attitude as a defender of the liberties of elected bodies, and still posing as the victim of the Public Bodies Order, although their attitude on this point was final when they allowed a mandamus to issue by default, have in reality entered on an entirely new crusade, the object of which is to deprive the medical superintendent of his position as the supreme head of the asylum, subject to the control of his committee, and to substitute for him a new authority to be known as the Chief Clerk, whom they have actually described as "their chief executive officer." In pursuance of this policy at the last meeting of the Asylum Committee held on Thursday last, the chairman of the committee proposed the following resolution :—

"The Joint Committee affirm their order holding the Chief Clerk responsible for conducting all correspondence of a non-medical character. All correspondence covered by this minute must in future, if addressed to any other official, be handed to the Chief Clerk."

Moreover, in further pursuance of it, the summonses to attend the meeting for apparently the first time were sent out signed by the chief clerk and not by the medical superintendent.

The speech of the chairman, in which he endeavours to justify his opposition to the present and legal position of the medical superintendent, does not appear to us to be either convincing in its logic or to be justified by the past relations of the medical superintendent to the Committee. The chairman is a most able gentleman, but when he states that he will not be a party to the farce of attempting to hold an official responsible for duties which he is physically unable to perform or even to supervise, we fear that he allows his desire to appeal to the unthinking public to run away with his common sense. May we ask him two questions? Did he ever hear of a head official of any great institution who was capable of physically performing the duties for which he was responsible? The answer is so obvious that we should have concluded that the chairman had been incorrectly reported, had he not previously stated that the Local Government Board had delegated to the medical superintendent the *personal* inspection and rejection of every cast-off garment of the 2,900 inmates of the asylum. Of supervision, however, the responsible head of an institution must be capable, and so follows our second question. How comes it that if Dr. Connolly Norman has been all these years incapable of supervising the institution of which he is the legal head, that not a single instance of neglect can be brought up against him; how is it that at the end of twenty years' service the Committee deliberately state that they are satisfied with his record; and how is it that Mr. Jones, as chairman, has allowed so gross a scandal to continue?

The asking of questions is at times a vain pursuit, but having once commenced them perhaps we may be allowed to ask others. How is it that the chief clerk was allowed to represent himself to the Committee as the lineal descendant of the last secretary of the institution, seeing that some twelve years ago the office of secretary was deliberately abolished with the object of preventing dual control? How does it come about that the Committee were told that, the answer given by Mr. Herbert Gladstone to a question asked by Mr. Gogan in the House of Commons was as follows :—

"The Clerk of the Asylum is entrusted by statute with the keeping of accounts, books, and documents in respect of which he is therefore directly responsible to the Committee. As regards Scotland, clerks and treasurers of District Lunacy Boards are naturally solely responsible to those Boards."

when Mr. Gladstone's actual answer reads thus :—

"There are no secretaries or accountants in public asylums in England and Wales. The officers who deal with the supply and distribution of stores, the keeping of certain books and documents, and of the accounts of receipt and expenditure, are (1) the clerk and steward, the two offices being almost invariably held by the same person; and (2) an outside independent auditor. The former being resident is usually subordinate and immediately responsible to the medical superintendent, who has paramount authority in the asylum subject to the supreme control of the committee of management, statutorily called the visiting committee; the latter is responsible, and reports to the visiting committee alone. The clerk of the asylum is entrusted by statute with the keeping of accounts, books, and documents, in respect of which he is therefore directly responsible to the visiting committee. As regards Scotland, clerks and treasurers of district lunacy boards are naturally solely responsible to those boards."

We have no desire to represent the chairman's views in anything but the most exact manner, but there must be something incorrect in their mode of expression

when they lead the daily press to head its report of the committee's meeting with such notices as "New Local Government Board Ukase"; "Chief Clerk's Duties imposed on Dr. Norman." What is the new ukase, and what duties of the chief clerk have been imposed on Dr. Norman?

We think that if the chairman had been wise he would not have allowed himself to be drawn into an attempt to blind the general public to the true state of affairs. The Local Government Board have issued no new ukase, they have drawn the attention of the committee to the statutory duties of the medical superintendent, and they have intimated that they will not allow those duties to be delegated to a new official. The chief clerk's duties have not been imposed on Dr. Norman, but a deliberate attempt has been made to remove the medical superintendent from his position as supreme head of the institution. This is the vital point in the whole matter, and that which has compelled us to devote so much space to what at first sight may appear to be a trivial dispute between medical superintendent and managing committee. The question at issue is not whether Dr. Norman is to personally examine the cast off clothes of some 3,000 patients, as the chairman would have us believe, but whether the management of lunatic asylums throughout Ireland is to be removed from the medical superintendents and vested in minor officials. Mr. Jones has endeavoured to insert the thin edge of a wedge calculated to shatter the firm foundation on which the treatment of the insane has been gradually placed. Should its insertion be permitted, the time will soon arrive when instead of hospitals for mental disease—the position which lunatic asylums should occupy—we shall witness a reversion to the mad-house of the past. We are confident that the last person who desires such a state of affairs is the very capable chairman of the Richmond Asylum, but we fear that, like many other well intentioned persons, he has not looked forward to the ultimate consequences of his, no doubt, well-intentioned actions.

It is well to know that the serious attack on asylum management has been brought to the notice of the Medico-Psychological Association of Great Britain and Ireland and that the following resolution has been unanimously adopted by that body:—"The Medico-Psychological Association of Great Britain and Ireland, having learnt, through reports in the public press, of a movement in Ireland tending to lessen the authority of the resident medical officers of asylums, desires to express in the strongest manner its conviction that any such change would certainly result in injury to the patients, and would be in direct opposition to all progressive and enlightened treatment of the insane." With prudent foresight, the Association have further directed that a copy of this resolution shall be delivered *into the hands* of the Chief Secretary for Ireland.

LABORATORY NOTES.

ALLENBURYS' FOODS FOR INFANTS.

A SHORT hour in the train, a walk through the somewhat quiet village of Ware, a stroll for half a mile along the banks of the canal (Lea Navigation) where many disciples of Isaac Walton sleepily regard and probably silently anathematise the unaccustomed disturbers of the tow path, a passage over a rustic bridge overlooking a lock, a hundred yards along a road, and Messrs. Allen and Hanbury's factories are reached. The road separates the part devoted to the manufacture of jujubes and soaps, the grinding of drugs, the distilling of oils, &c., from the buildings where the three Allenbury foods are made. Leaving the latter block of buildings on the right as a *bonne bouche*, the investigator may employ with advantage some little time in viewing the various methods of filling the jujubes—making, fashioning into various shapes, stamping and packing soaps, dealing with many different drugs, poisonous and non-poisonous, distilling oils, especially sandalwood oil; but there are two things that must strike the observer during his pilgrimage through the various departments; the first is the scrupulous cleanliness that exists everywhere, not only in the machinery, not only in the floors, walls, etc., of the sheds, but also in the persons and dress of the employees, both male and female; the second is—and how important it is in these days of strikes and unemployed—the absolute happiness, combined with a look of pleasure in their work, which pervades the faces of all the work-people. Crossing the road again and also a bridge over the river Lea itself (the power of the stream being here mechanically utilised) we reach the various buildings in which the Allenbury foods are made. One of the first things to attract attention is the endless stream of milk carts going and coming; this can be quite understood if it be realised that thousands of gallons of milk are delivered daily at the factory. The milk is tested by a trained chemist to ascertain whether it is of the requisite quality. It is most interesting to follow in the different houses the processes through which the milk goes before it is finally reduced to a fine dry powder ready for packing. The most important, as the cow's milk is to be transformed into a food for infants, are the extraction of the excess of casein, and the making good of the deficiences of fat and milk sugar, both these being effected after the cream has been temporarily removed by the milk being passed through separators. The reduction to a powder is brought about by evaporating in vacuo. Here, again, one is struck by the perfect cleanliness of all the buildings, even of the engineering workshop, and with the contented faces of the employees; the cleanliness is not only superficial, but is also hygienic and sanitary. From analysis of these infants' foods, No. 1 for the first three months of a child's life; No. 2 from third to sixth month; No. 3 after six months—we find them absolutely free from harmful bacteria and besides they are so prepared that they approximate as closely as possible to human milk, and as such they are a boon to humanity especially in the present day, when unfortunately fashion on the one hand and hard work by the female breadwinner on the other prevents most women giving their babies the sustenance provided by Nature.

REVIEWS OF BOOKS.

THE TREATMENT OF SPINAL CURVATURE. (a).

THIS book constitutes an instalment towards a complete work engaged in by the author on "The Deformities, Debilities, and Deficiencies of the Spine." Some previous parts, as that on "Caries," already published, deal with singular and particular diseases of the spine only. The present volume reviews the broad principles which underlie the successful mechanical treatment of all lapses of the spinal column. The author, Mr. Heather Bigg, states:—"All errors of the spine, whatever their origin, whether from disease or disorder, are mechanical in results, and all treatment of such errors must also be mechanical in method and intent." The essay is written to substantiate the above statement by evidence which the author considers as indisputable, and by a critical analysis of other methods of treatment.

The treatise is divided into seven sections. Section I. discusses the primary principles of mechanical treatment. Sections II. and III. give an interesting account of the evolution of mechanical treatment from the time of Hippocrates, B.C. 400 to A.D., 1870. About the latter date the author commenced to make a special study of this subject. Section IV. deals with adjunctive treatments used about 1870, as the Couch, the Seat, and the Boot treatment. Section V. is the most important. It describes the apparatus as perfected by the author, and discusses fully the principles of

(a) "An Essay on the General Principles of the Treatment of Spinal Curvatures." By Heather Bigg, F.R.C.S.Ed. London: J. and A. Churchill, 1905. Pp. viii. and 240.

mechanical treatment employed in its construction. In this connection Mr. Bigg has the advantage of being able to use for his guidance the careful record of cases dating from 1825 to 1870, in which the mechanical treatment was carried out by apparatus made by his grand father, Mr. Henry Bigg, and his father, Mr Heather Bigg. The principles involved are two—(1) The weight of the trunk must be up-buoyed; (2) active force of some kind must be brought to bear on the errant parts of the body. At the same time, vacant spaces must be left over the recessions of bodily error, so that these parts may have ample room left into which they may pass as the body straightens. The whole method of treatment depends on the graded alterations in the shape of the appliance, so that as the body changes for the better the spring force of the appliance may follow it up by persistent steps until successively enforced improvements culminate in complete straightness. The objection to Sayre's jacket is that though it presses on the prominences, it also presses with equal force on the recessions, which are therefore precluded by lack of room from any rectification. An efficient and easy method of overcoming this difficulty when using plaster of Paris jackets in hospital practice is described. Section VI. contains a criticism on other methods of treatment in use from 1870 to 1905. Sayre's jacket and the gymnastic treatment are particularly dealt with. Section VII. consists of a critical analysis of Mr. Roth's book on the gymnastic treatment of spinal curvature.

The essay on spinal curvatures is well printed, and suitably illustrated with the author's own photographs and sketches. In it Mr. Bigg constitutes himself the champion of the mechanical treatment of spinal curvatures, and as such attacks other methods vigorously and at considerable length. But in so doing he does not fail to make clear his own position, and also to produce a work which will be found both interesting and instructive. S.

BELL'S SURGERY FOR NURSES (*a*).

THE sixth edition of this ever-popular book needs no detailed notice. The former edition has been revised and brought up to date, and forms a model of clear and concise popular scientific writing. In addition to the technical matter an appendix appears for the first time "on the relation of the trained nurse to the profession and the public." This survey is written with keen insight into the facts of a somewhat complicated relationship, and should be carefully perused by every member of the nursing profession. The book is full of apt aphorisms, as for example, "nurses are employed rather by the medical profession than by the public." We can cordially recommend this little volume to all interested in the subject.

YEAR-BOOK OF PHARMACY. (*b*)

THIS year-book contains a wealth of information for the pharmaceutical chemist, and much also that is of interest to the ordinary medical practitioner. We have here abstracts of the papers dealing with Pharmacy, Materia Medica and Chemistry, which have been contributed to British and Foreign Journals from July 1904, to the end of June, 1905. It is impossible with the space at our disposal even to mention the many papers and reports which the volume contains, and to the book itself we must refer our readers who wish to find out what has been done in the various departments of pharmaceutical chemistry and where it has been reported. We should wish especially to draw attention to Dr. W. E. Dixon's plea for the Bio-chemical standardisation of certain drugs, which cannot be satisfactorily assayed by chemical means. Such drugs are the members of the digitalis group, ergot and Indian hemp. The latter a drug of considerable importance is perhaps the most variable of all the materia medica, yet the ordinary method of assaying it by the determination of the total amount of resin which it contains is said to be practically worthless. If such potent drugs are to be used in the treatment of disease, at least the physician should demand that preparations of them should be of uniform strength. This being so, we hope that in the near future the bio-chemical method of standardisation, where necessary, will become compulsory.

(*a*) "Notes on Surgery for Nurses." By Joseph Bell, M.D., F.R.C.S.Ed. Oliver and Boyd, Edinburgh; Simpkin, Marshall, London, 1906. 2s. 6d.

(*b*) "Year-Book of Pharmacy with the Transactions of the Pharmaceutical Conference at the forty-second annual meeting, held in Brighton, July, 1905." Editor of the Year-book, J. C. Braithwaite. Editors of Transactions, E. Saville Peck, M.A., and Edmund White, B.Sc., F.I.C. London: J. & A. Churchill, 1905.

WALLER AND SYMES ON PRACTICAL PHYSIOLOGY (*a*).

THE second part of this useful laboratory hand-book deals with those exercises in chemical and physical physiology which students can perform for themselves, together with more advanced operations partaking of the nature of formal demonstrations. Nearly half the book is taken up with the experiments connected with the blood and circulation. An ingenious sphygmomanometer (human) is described in which the radial artery is compressed by an inflated finger-stall joined up to a small mercurial manometer. The remainder of the book is occupied with food-stuffs, digestion, muscle and urine. The directions given throughout are concise but quite explicit, and there are some useful diagrams and charts.

LITERARY NOTES.

THE question is sometimes asked, "Who reads all the medical books that are published?" an impossible question, of course, to answer. Nor is the solution assisted by a glance through Mr. Lewis's new "Catalogue of Medical and Scientific Library," just issued. This only includes works from the various medical publishers during 1902–1905, yet it contains upwards of 1800 titles, and catalogues compiled by Mr. Lewis prior to this date give 7,200 titles in addition. When it is remembered that for the subscription of a guinea per annum to this circulating library access can be had to this marvellous production of medical authors some faint idea of labour if not of study can be gleaned.

MR. WILLIAM FIELD, M.P., sends us a copy of his pamphlet entitled "Ireland and Imperial Expenditure." It contains reprints of four articles contributed to the *New Ireland Review*, together with newspaper comments, questions in Parliament, letters, and other documents, relative to the subject. Mr. Field's writing is in his usual trenchant style, and he gives many striking examples in support of his contention that a fair proportion of Imperial expenditure does not go to Ireland. Among other illustrations are the facts that Army Medical Service advertisements are refused to any medical papers outside London and that successful candidates for the Royal Army Medical Corps are, or were, bound to purchase their uniforms from London tailors.

MESSRS. DOLLARD, LTD., of Dublin, publish a very excellent little book by Surgeon-Lieutenant MacCabe, entitled "War with Disease." It consists of four lectures on the subject of preventive medicine, delivered a few months ago to the Officers, N.C.O.'s, and selected men of the Cavalry Brigade at the Curragh, by request of General Rimington. Dr. MacCabe has performed a very difficult task with complete success. He has explained in straightforward, plain language, the essentials of personal hygiene as applicable to soldiers, and this not only in general, but in relation to certain of the more important diseases. The lectures are avowedly popular, but they are at the same time thoroughly scientific. They should be read by every soldier, whether commissioned or private.

(*a*) "Exercises in Practical Physiology." By A. D. Waller, M.D., F.R.S. Part II. Exercises and Demonstrations in Chemical and Physical Physiology. Pp. 79. London: Longmans, Green and Co., 1905. Price 2s. 6d. net.

MEDICAL NEWS IN BRIEF.

St. Mary's Hospital, London.

AT the annual distribution of prizes to the students of the medical school last week the Dean (Dr. H. A. Caley) reported that the number of students was approximately 230. The examination results for the year had been satisfactory, 25 students had obtained diplomas of M.R.C.S. and L.R.C.P., 18 the M.B. degree of the Universities of Oxford, Cambridge, London, or Durham, and four that of M.D. Mr. M. F. Kelly had been awarded the gold medal in surgery at the B.S. examination of the University of London, and Mr. A. F. Hayden, who obtained the third place in the entrance examination for the Indian medical service, had won the Montefiore bronze medal and prize in military surgery and the Martin prize in military medicine. In referring to the naval and military medical services, the Dean mentioned that St. Mary's was represented by 148 former students —64 in the R.A.M.C., 48 in the Indian medical service, and 36 in the medical service of the Royal Navy. Surgeon-General Sir Alfred Keogh, Director-General of the Army Medical Service, gave away the prizes, and, addressing the students, said he was glad to see that the school was so well represented in the public services, especially in that branch to which he had the honour to belong. The steps taken by the General Medical Council would uphold the honour and dignity of the profession, and their outlook was better than it had ever been before. The company afterwards proceeded to the entrance hall of the Clarence wing, where Mr. Harben, as chairman of the board of management, invited Sir Alfred Keogh to unveil a bronze mural tablet in memory of seven members of the hospital and medical school who fell in the South African war. In doing so, the Director-General said that he hoped the memorial would be an incentive, if the country ever required their help, to the students to come forward and do as their brave comrades had done.

Royal University of Ireland.

THE RIGHT HON. SIR ANDREW M. PORTER, BART., Master of the Rolls, and Sir William Anson, Bart., D.C.L., M.P. for Oxford University, held a public visitation at the Royal University on Friday last, for the purpose of inquiring into the existing regulations respecting the holding by students of the University of fellowships, scholarships, or other emoluments or prizes in other Universities or colleges than the Royal University.

Mr. C. F. Doyle, K.C., Examiner in Law to the University, said that the question with which the visitation was concerned arose on the construction of Section 9 Sub-section 14 of the University (Ireland) Act of 1879, which was as follows:—

Provision shall be made that no student holding any exhibition, scholarship, fellowship, or other similar prize in any other University or in any college attached to a University, or in any college endowed with public money, shall hold any of the said exhibitions, scholarships, fellowships, or other prizes in the University without taking the value of such previous exhibition, scholarship, fellowship, or other similar prize into account.

The doubts and difficulties which had arisen were almost entirely confined to the question as to the interpretation to be put on the words "holding" and "hold" in that sub-section. In accordance with that enactment the University regulations contained the following provisions.:—

No student holding any exhibition, scholarship, fellowship, or other similar prize in any other University or in any college attached to a University, or in any college endowed with public money can hold any of the exhibitions, scholarships, fellowships, or other prizes in the Royal University without taking into account the value of such other exhibition, scholarship, fellowship, or other similar prize.

Sir William Anson said the visitors had come to the conclusion that the resolution of the Senate proceeded on the assumption that it was possible to construe the word "holding" as "having held." The visitors did not consider that that was a possible construction, that the student who was disqualified from holding a prize of any sort at the Royal University must be actually holding some prize of the sort included under the Sub-Section. It would follow, therefore, that the resolution of the Senate was *ultra vires*. They (the visitors) considered that the word "previous" could not be construed, as suggested, as equivalent to "aforesaid." Therefore, it was possible for a student to hold two of these prizes at the same time, so long as at the moment he was awarded a prize at the Royal University he was not holding a similar prize previously obtained. They further held that a scholarship which had run out in June at the end of the academical year would not affect an exhibition or other prize obtained at the Royal University and awarded in July. In regard to a sizarship in Trinity College, they were of opinion that it must be regarded as a "previous exhibition, scholarship, fellowship, or other similar prize," and, therefore, as not tenable by the students of the Royal University. As regarded the appeals from students who held allowances from the Department of Agriculture, the views of the visitors were that these are not held from colleges endowed by public money, but from a public department, and that therefore they are not affected by the words of the sub-section.

Army Contractor's Potted Ham.

ON the 19th inst., the Brentford Bench had before them three summonses arising out of the sale of potted meat. The defendants were Messrs. Dickeson and Co., Limited, London, and Mr. A. J. Mileson, of Brentford. There were two summonses. In the first Messrs. Dickeson were charged with having sold potted ham containing 0·74 per cent. of boracic acid, equal to 80 grains of borax per pound, and, further, that the sample had been coloured with oxide of iron. In another instance, it was alleged to contain 1·2 per cent., equal to 129 grains per pound. Against Mr. Mileson the summons was for selling brawn which contained 0·398 per cent. of boracic acid, equal to 42.9 grains of borax per pound. Also that the sample was coloured with a pink coal tar dye. The summons against Messrs. Dickeson alleging 1·2 per cent. of boracic acid was adjourned on a question of analysis. The case as regarded the sample containing ·74 of boracic acid was then dealt with. Mr. Smith said the defendants had large contracts for the Army. The potted ham was purchased in the canteen at Hounslow Barracks, three tins for a penny apiece. Mr. Beavan, analyst, said that if good meat was used, and it was properly sterilised and kept in hermetically sealed tins, the product would keep without the application of boracic acid. Dr. J. S. Sykes, Medical Officer of Health, gave evidence that the use of boracic acid was injurious to health. Dr. W. H. Wilcox, Lecturer on Public Health at St. Mary's Hospital, held that boracic acid ought not to be used in potted food at all. Two children were admitted to the hospital suffering from malnutrition. They were fed on cream which it was subsequently ascertained contained boracic acid.

They died, and it was the opinion of himself and other physicians that the use of this acid had brought about the deaths. Mr. Otto Hehner, for the defence, said he had examined samples of all the best makes of potted meat. Out of 23 samples, 20 contained boracic acid. Experiments had been made daily on forty millions of people in England for fifteen years, and no conclusive case of injury had been proved. Professor S. W. Tunnicliffe said he was a member of the Departmental Committee appointed by the Local Government Board to inquire into the use of preservatives and colouring matter. As a result of his investigation and the evidence before the Council, he formed the opinion that the use of boracic acid was justifiable, and was unlikely to be injurious to a healthy ordinary individual. The Chairman said they were unanimously of opinion that the article sold was rendered injurious to health by the addition of as many as 52 grains per pound of boracic acid to it. The defendants were fined £5 and fifty guineas costs. The case against Mr. Mileson was taken next. The Bench fined defendant 40s. and costs.

[Elsewhere, in the present issue, we comment upon a conviction for boracic acid adulteration, with certain recent medical views upon the whole matter.—ED.]

Irish Medical Schools' and Graduates' Association.

A CONVERSAZIONE and dance will be given by the Irish Medical Schools' and Graduates' Association, at the Hotel Great Central, London, on Thursday (to-morrow), July 26th, at 9 p.m., to meet the Council and Representatives of the British Medical Association. Members of the Irish Medical Schools' and Graduates' Association can obtain tickets from Mr. Canny Ryall, F.R.C.S.I., 85, Harley Street, W.

The Coal Tar Jubilee.

TO-MORROW Dr. Perkin, whose name is associated with the discovery of sulphonal, aspirin, carbolic acid, and anti-pyrine, and the analine dyes will be presented at the Royal Institution with his portrait and bust on the occasion of the Jubilee of the Coal Tar Industry. In the evening a banquet will be held at the Whitehall Rooms, at which many distinguished guests are expected.

British Pharmaceutical Conference.

THE annual session of the Pharmaceutical Conference is taking place at Birmingham this week, under the presidency of W. A. Naylor, F.I.C., F.C.S. The daily meetings will be held in the University, the last being on Friday next. Receptions will be held by the Lord Mayor and by Mr. Thomas Barclay, J.P. (vice-President), to the medical profession, about forty of whom have accepted invitations, and to members of the Conference. Mr. Barclay's reception will be held this evening (Wednesday) in the Botanical Gardens, which will be illuminated, a display of fireworks will take place after which a cinderella dance. Visits will be paid during the session to Messrs. Cadbury's model village, to the Royal Porcelain works at Worcester, Messrs. Osler's glass works, to Kenilworth, and other places of interest, and altogether the meeting promises to be of exceptional interest.

Food Inspection.

IN a report just issued, the Medical Officer of the Borough of Holborn recommends that the name and address of the manufacturer. and the date of canning of foods should be impressed on the cans; that tins which were known in the trade as "doubtfuls" should be deemed unfit for home consumption; that food intended for canning should be inspected by independent officials prior to being canned; that all foods should be canned under strictly hygienic conditions; and that the use of preservatives in canned foods should, under no circumstances be permitted. The Public Health Committee reports that during the past month 32 samples of canned or potted meats of various kinds were purchased and submitted to the borough analyst for examination, from whose report it appears that, with the exception of one tin, which was "blown," and which was returned, the whole of the meat was found to be generally in good condition. Preservatives were detected in only four cases, and in very small quantities—viz., boric acid to the extent of 0.5, 0.125, 0.07, and 0.05 respectively; in a few instances slight traces of nitrates were discovered, probably added for colouring purposes. "It is of interest to note," add the committee, "that the preservatives were discovered in home-canned goods, none being found in American or other imported tins."

Royal College of Surgeons of Edinburgh.—The Fellowship.

THE following gentlemen, having passed the requisite examinations, were at a meeting of the college held on 20th inst., admitted ordinary Fellows—Charles Henry Allen, M.B., Ch.B., Metheringham; James Reginald Atkinson, M.B., C.M., Crewe; Kaikhusru Dadabhoy, L.R.C.S.E., Edinburgh; John May Darling, M.B., Ch.B., Edinburgh; William Henry Duncan, L.R.C.S.E., Maryhill; Samuel Linley Heald, M.B., Ch.B., Leeds; Thomas Walter Irvine, M.B., C.M., Major, Indian Medical Service; Joseph Alan Longley, M.B., Ch.B., Leeds; John Clark Muir, M.B., Ch.B., Edinburgh; John King Osborne, M.B., C.M., New South Wales; George Potts, L.R.C.S.E., Maidstone; Andrew Taylor Ross, M.D., Glasgow; David Herman Wessels, M.B., Ch.B., South Africa, and Alfred Lambre White, L.R.C.S.E., Edinburgh.

Royal College of Physicians and Surgeons.

SECOND PROFESSIONAL EXAMINATION.—Candidates have passed this examination as undernoted: July, 1906—R. Adams, Miss I. M. Clarke, E. C. Deane, H. S. Meade, J. Menton, Miss A. F. Nash, and Miss C. F. Williamson (with honours), P. N. Allman, S. J. Barry, G. E. Beggs, B. G. S. Belas, W. Breen, H. F. Blood, T. G. Brown, P. A. Doyle, E. Dundon, B. H. Farrell, J. F. Gibbons, Miss M. K. Griffin, E. Harrison, F. N. Harvey, W. Hederman, H. S. Johnston, C. Kelsall, P. M. J. Power, R. Power, R. H. Taaffee, P. T. Warren, J. D. Williams, Miss Nora Williams, and O. W. J. Wynne.

THIRD PROFESSIONAL EXAMINATION.—S. Blake, T. C. Boyd, W. H. Bomford, S. Broderick, T. Cormac, W. F. S. Davis, J. Ellenbogen, B. Foley, W. F. Lane, G. S. Levis, J. E. Moffatt, J. M'Namara, C. M'Queen, J. V. O'Hagan, W. H. O'Riordan, D. O'Sullivan, G. F. Shepherd, and J. M. Warnock.

Trinity College, Dublin.

Intermediate Medical Examination—Part II.—Richard P. Hadden, Samuel F. A. Charles, and John L. Phibbs (passed on High Marks); Henry H. Ormsby, Albert V. J. Richardson, Herbert V. Stanley, Frederick A. Anderson, Charles W. Laird, George Halpin, George B. McHutcheson, Gerald G. Mecredy, Robert de C. Wheeler, William E. M. Armstrong, Edward J. H. Garstin, Frederick R. Sayers, Duncan F. Hunter and Henry R. Kenny, equal Arthur H. Laird, Harold S. Sugars, Richard T. Attridge, John C. Baker, William H. Sutcliffe, William H. M'Carthy, Frank Smartt.

Fitzpatrick Scholarship:—Ralph S. Oldham.

Medical Scholarships:—Anatomy and Institutes of Medicine—Johannes C. Pretorius, Trinity College Scholarship; Samuel F. A. Charles, Stwart Scholarship. Physics, Chemistry, Botany, and Zoology—Arnold K. Henry, Trinity College Scholarship; David Duff, Stewart Scholarship. Purser Medal in Institutes of Medicine—Richard L. Hadden.

Society of Apothecaries of London.

THE following candidates having passed the usual examination, have received the L.S.A. Diploma of the Society, entitling them to practise medicine, surgery, and midwifery:—H. J. May. J. L. Meynell, E. Morris, and E. J. F. Thomas.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS.

ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT SURGICAL LITERATURE.

The Surgical Aspect of Anuria.—Cumston (*Glasgow Medical Journal*, July, 1906) outlines a classification of conditions giving rise to various forms of anuria. Those cases resulting from reflex action are first considered. To this class belong the anuria of hysteria, toxic anuria arising from the intestinal canal, and also instances of suppression of urine caused by an irritation arising in one kidney, which irritation, by what is probably a reflex action, prevents the secretion of urine from the healthy organ as well. The anuria in these cases can usually be traced to a reflex contraction of the renal bloodvessels, especially the arteries. A cure followed deep chloroform narcosis in a case of absolute anuria which had lasted eleven days. Obstruction of one ureter as from calculus, or in movable kidney sometimes gives rise to the so-called sympathetic anuria. Cohnheim came to the conclusion, after some experimental work, that in complete obstruction of the ureter hydronephrosis can only occur to a mild degree, because the enormous tension set up rapidly produces a failure in the secretory power of the organs; and that marked hydronephrosis arises only in incomplete obstruction of the ureter. Anuria may follow the removal of one kidney. It arises under these conditions either from the fact that the opposite kidney is diseased and functionless or that the heart, which may have been undergoing pathological changes for some time, has its action weakened from the narcosis and loss of blood, so that ischæmia of the kidney results, causing rapid degeneration of the renal epithelium, and with this cessation of its function. The author considers that aseptic technique in nephrectomy is of more importance than the choice of the anæsthetic. He points out the deleterious action on the kidney of certain antiseptics, as carbolic acid, iodoform, and especially bichloride of mercury. In anuria due to cholera a marked venous hyperæmia of the kidney is found. The oliguria and anuria in severe cases of diffuse nephritis appears to find an explanation through the almost complete blocking up of the urinary canals with casts. Renal calculus is the most frequent cause of anuria. There is only one recorded case in which both ureters were obstructed by calculi at the same time, thus causing anuria, the two kidneys at the same time being in perfect functional order. There is the possibility for the occurence of calculus anuria, apart from reflex anuria, when only one kidney exists. Schwenger reports a case of this kind, where autopsy revealed the complete absence of the left kidney. Anuria due to ureteral obstruction from blood clot or compression from without is rare, and probably only occurs when the other kidney is functionally destroyed. In case of anuria operation should not be delayed longer than forty-eight hours. The kidney should be opened in order to give exit to the urine. The author cites a case of anuria of puerperal origin, in which bilateral decapsulation was done. Although some improvement followed, the patient died four days after the operation. The author believes that nephrotomy might possibly have saved the patient's life. S.

Some Points on the Surgery of the Lung.—Sir William Macewen (*Brit. Med. Journ.*, July 7th, 1906) discusses the condition of collapse or otherwise of the lung in perforating wounds of the chest. A man fell across a circular saw while in motion. As a result of the accident a slice was taken off the outer aspect of the right side of the chest and the visceral pleura was left exposed over an area as large as the palm of the hand. This exposed portion of the lung lay in contact with the atmospheric air and there was no collapse. In order to secure a bleeding intercostal artery, the visceral and parietal layers of pleura were separated, thus admitting air into the pleural sac. The lung as a result receded from the chest wall. On bringing the visceral and parietal layers of pleura together by direct pressure on the chest wall the two pleural layers coalesced and the lung again filled the aperture, as it did prior to the admission of air into the pleural sac. On the patient suddenly tossing round on to the uninjured side, the air again entered the pleural sac, and the lung receded markedly from the thoracic wall. When turned gently on his back pressure being made at the same time on his thorax, the two pleural layers were again brought into contact. The wound was at once closed with the flap, pressure being meanwhile applied, and the external parts were suitably fixed to prevent undue expansion of the chest on that side. From the observations of this and similar cases, the author concludes that should collapse of the lung occur to a limited extent that organ can be expanded again by the simple expedient of bringing together the two layers of the pleura and securing intimate contact between them. The normal amount of lubricating fluid between the two layers of the healthy pleura, usually augmented by the thin layer of liquid blood, aids in the coalescence of the two serous surfaces. Capillary attraction exists between the two moistened surfaces. The action of a biconcave meniscus is distinctly visible during the coalescence and separation of the two serous layers. In a case of traumatic pneumothorax it was seen that the lung was torn and a portion of the visceral pleura invaginated into it. A portion of the rib over the wound in the lung was removed and the visceral pleura stitched across the gap in the lung, which soon filled with blood clot; a light pad of antiseptic gauze loosely applied was inserted between the lips of the thoracic wound, which was thus kept open, and any air which might come from the lung would thus escape externally. Firm pressure was kept on the external thoracic wall above and below the wound by means of adhesive plaster, as if for broken ribs, and a firm roller bandage was applied. The relief to the patient was immediate and lasting. The wound in the lung soon closed, and the tissues of the thoracic wall were then brought together. In pathological conditions, when the pleural surfaces are covered by plastic exudation or layers of fibrinous patches, the power of molecular cohesion between the surfaces is greatly lessened or lost. There is also less elasticity and less recoil in the pulmonary tissue, and therefore less tendency to collapse and less capacity of expansion. Hence the necessity in many such cases of removing a sufficient portion of the osseous walls to permit the thoracic wall to come in contact with the lung. In the author's opinion the causation of primary shock in admission of air into the pleural sac is really due to the effect upon the heart. The vessels of the pulmonary circulation only anastomose at the periphery of the lung. The result of contraction of the lung, which takes place mostly at the periphery, is that the flow of blood through the minute vessels is greatly impeded or even arrested. The sudden arrest of flow of blood into the lung from the right ventricle produces a staggering effect on the heart which falters in action and results in dyspnœa and lividity of the cutaneous surface. S.

Paralysis of Recurrent Laryngeal Nerve in Mitral Stenosis.—Frieschner (*Wiener Med. Woch.*, 1905, No. 52) reports a case of a woman, æt. 30, who was suffering from mitral stenosis and regurgitation, and who developed paralysis of her left vocal cord three weeks before her death. At the autopsy the cause was

proved to be compression exercised by the greatly dilated and hypertrophied left auricle. This pressure was not, however, direct, but was exercised through the pulmonary veins and pulmonary artery, which by being displaced forwards compressed the recurrent laryngeal nerve against the aortic arch. The nerve fibres were degenerated upwards from this place. Up to this three possibilities have been regarded as the cause of the association of recurrent paralysis and mitral stenosis, namely (1) direct compression by the left auricle; (2) indirect pressure by the left auricle through the pulmonary artery; (3) similar indirect pressure exerted through the medium of the ligamentum arteriosum. M.

Primary Tuberculosis of the Conjunctiva.—Dr. J. J. Thompson (*Annals of Ophthalmology*, January, 1906) reports a case of the above in which the appearances were atypical rendering a diagnosis between tuberculosis and syphilis difficult. The patient sought advice about a pre-auricular gland which had become enlarged. The corresponding eye had felt "peculiar" for four weeks. The upper lid was very slightly swollen, and on the conjunctival surface there was a small (2 mm.) ulcer, with clean-cut edges, clean base (unusual), and no surrounding induration. Notwithstanding the absence of the induration, Thompson had a strong leaning towards the ulcer being syphilitic. There was no family history or physical signs of tuberculosis. The excised gland gave anatomical tubercles with a fair number of giant cells. A guinea-pig whose peritoneum had been inoculated with scrapings of the ulcer, died in 35 days from general tuberculosis. The ulcer and surrounding tissues were thoroughly removed. Progress was favourable, the ulcer being healed in two weeks, and the patient kept in the best of health. Thompson thinks the infection must have occurred through a small abrasion of the conjunctiva, as, according to Valude, the tubercle bacilli will not penetrate the intact conjunctiva. M.

Interscapulo-thoracic Amputation for Sarcoma of the Scapula.—John Douglas (*New York Med. Journ.*, June 9th) records a successful case of removal of the arm and scapula for sarcoma. Berger's method was followed: (1) Incision over the clavicle; (2) subperiosteal resection of its outer two-thirds; (3) ligation of the subclavian artery and vein; (4) division of the pectoralis major and minor; (5) injection of the brachial plexus with 1 per cent. cocaine solution; (6) shaping flaps, division of the brachial plexus, division of the latissimus dorsi, with turning back of the arm and scapula; (7) division of the muscles attached to the scapula; (8) closure of the wound. The patient was allowed out of bed on the sixth day. The mortality of the last 153 similar cases is only 7·8 per cent. The average duration of life after the operation is only three years. G.

Renal Casts and their Clinical Significance.—In a paper on this subject, Benjamin Clive (*The Post Graduate*, June) refers first to the origin of renal casts. He believes that they are composed of exuded coagulable elements of the blood, which enter the renal tubuli as a result of pathological changes in the latter, and these solidify, forming moulds (casts) of the tubules. A second theory is that they consist of a secretion from the irritated epithelial lining of the renal tubuli, which later solidifies and forms casts. Lastly the theory is held by some observers that the casts are products of disintegrated renal tubular epithelium, which coagulate and are washed out with the urine. The clinical significance of the presence of the various forms of renal casts is then dealt with. Hyaline casts are not pathognomonic of any one abnormal state; they are common in the urine of most persons over 40 years of age, with, as well as without, the slightest passive hyperæmia of the kidney, or an acute or chronic trace of albumin, and may occur in the urine for years without any evidence of a kidney lesion. This applies also to granular casts the finely granular casts occurring in healthy urines. The coarsely granular usually are associated with marked degenerative changes in the renal epithelium. Epithelial casts point to active or parenchymatous nephritis. Pure pus casts are comparatively rare, and when found indicate an infective suppurative process in the kidney. Blood casts are found in the urine in conditions where hæmaturia is of renal origin, and renal hæmorrhage from any cause may accompany them. They are not in themselves positive evidence of organic renal disease. Fatty casts usually indicate chronic interstitial, or chronic parenchymatous nephritis. Mixed casts are not pathognomonic of any one type of renal disease, their diagnostic value is dependent on their number, and the predominant cellular elements. Waxy casts may occur in the absence of any amyloid disease in the kidney; on the other hand, kidneys which are extensively amyloid may not cause any waxy casts in the urine, their diagnostic value is therefore not high. Cylindroids are found under much the same conditions as hyaline casts, and are of no great significance. Mucous threads may originate from any part of the urinary tract, but are usually found in connection with irritation or inflammation of the lower urinary passages. G.

Analyses of 186 Operations upon the Liver and Gall Passages and the After-Results.—C. McWilliams (*New York Med. Journ.*, June 2) gives a critical analysis of 186 operations on the biliary passages. In 69 of the cases it was possible to follow up the after-history as well as the immediate result of the operation; 65 per cent. were cured; 10 per cent. were improved; 12 per cent. required secondary operations; 9 per cent. developed subsequent hernia in the wound. In 10 per cent. calculi had been overlooked at the first operation. The author then describes fully the cases in which secondary operations had to be performed. From these patients he draws the following conclusions: (1) More thorough search for calculi at the primary operation, splitting the ducts wide open, if necessary. (2) Provided it were possible of performance, a primary cholecystectomy would have avoided the necessity for a secondary operation, in nearly all the cases. (3) In only one of the cases had a primary cholecystectomy been performed. This speaks very strongly for the removal of the gall-bladder at the primary operation, since it seems to give the greatest guarantee against future difficulties, hence the greater certainty of a cure. G.

Injuries to the Eye during Birth.—S. Stephenson (*Brit. Journ. of Children's Diseases*, 1905) related how Beaumont, Snell, Thomson, and Buchanan have reported cases of *dislocation of the eye* during birth. As a depression of the cranial bones has generally coexisted, Thomson and Buchanan designated the injury as an "extrusion," rather than a "dislocation." Stephenson refers to the case quoted by de Wecker, where an accoucheur, mistaking a face for a buttock presentation, managed to gouge out the baby's eye with his finger. Besides injury to the facial nerve, other *cranial nerves, e.g.*, the third, fourth and sixth, may be paralysed from injury during birth. The mechanism of the injury is not known beyond doubt, but it is probably due to fractures of the bones of the orbit or to intra-cranial or intra-orbital extravasation of blood. The transient nature of these paralyses is in favour of the last-named causes. In Küstner's case the third, fourth, sixth, and seventh pairs were affected, the paralysis was found after death to have been caused by hæmorrhages at the base of the brain, and lesions of the orbital walls. M.

The Relief of Cicatricial Orbit.—Dr. J. M. Ball (*Annals of Ophthalmology*, October, 1905) reports two cases of cicatricial contraction of the orbit in which the patients were unable to retain the artificial eye. He performed Maxwell's (Dublin) operation on the lower cul-de sac. On the upper cul-de-sac he made a Thiersch graft. Both cases did well, and after a year the wearing of the artificial eye remained comfortable. M.

NOTICES TO CORRESPONDENTS, &c.

☞ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to 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 proofs.

CONTRIBUTORS are kindly requested to send their communications if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

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.

PANCREAS.—There are considerable difficulties about the amalgamation. It was suggested by the Departmental Committee, but a Royal Commission would probably be needed. The Board of Education are now preparing a scheme.

NEMO (Wales).—The matter being hung up leaves us in the dark at the moment. A lecturer in lunacy would be needed at a fully-equipped university.

LECITHIN.—The situation fortunately does not often occur. Your best plan would be to call on the doctor whose name has been mentioned, and tell him the circumstances frankly. We feel sure there is a misunderstanding, and the course we suggest is the right way to clear it up. It would be better not to visit the patient again, if you can avoid doing so, till you have seen the doctor.

HEART FAILURE.

The old cause of death
Was the "shortness of breath,"
But that is too vulgar by far;
The more modern "tale,"
Our hearts must all fail
Before we go "Crossing the Bar."

This foregone conclusion
Is oft a delusion,
But yet when we hear someone dies,
There is never a pause
To consider the cause—
"Heart failure," of course! someone cries. —A. D.

T. W. B.—We think that you have been misled by the information given you. If you refer to any standard work on therapeutics you will find that the treatment suggested is not generally approved by those who have had most experience of it.

SPECIALIST.—The new Code for 1906-7 was issued by the Education Department on July 1st. In it you will find that the changes you anticipate have been included.

APPLICANT.—The post of Assistant Medical Officer of Health for the Orange River Colony has been added to list of pensionable offices, but the appointment has recently been filled.

A FAMOUS NASSAU SPA.

IT so happens that one of our staff is in a position to answer your query about Schlanzenbad. The atmosphere is bracing and the scenery magnificent. From a medical point of view the chief attraction lies in the springs, which are famous for their beneficial action upon many diseases of the skin. The hotel accommodation is excellent. Any further information can be got by writing to Herr Winter, Hotel Victoria, Schlanzenbad, Germany.

ERRATA.—In our review last week of Dr. Shaw-Mackenzie's book on "The Treatment of Cancer," two printer's errors crept in: Glycogen should have been spelled Glycosen, and Crepsin should be read as Erepsin.

ELOMENSIS.—It is not uncommon for dogs to be supplied with artificial limbs after amputation. The whole subject is dealt with in a most interesting way by Professor Hobday in a book recently published by Baillière and Cox on "Diseases of Cats and Dogs."

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JULY 25th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. C. Ryall: Clinique. (Surgical).

THURSDAY, JULY 26th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical).

Vacancies.

Egyptian Government.—Ministry of Education.—Professor of Midwifery and Gynæcology. Salary £400 a year, with private practice. Applications to the Director, School of Medicine, Cairo, Egypt.

Egyptian Government.—Ministry of Education.—Medical Tutor and Registrar to Kasr-El-Ainy Hospital. Salary £400 a year. Applications to the Director, School of Medicine, Cairo, Egypt.

Galway Hospital.—Resident Medical Officer and Compounder of Medicine. Salary £75 per annum, with apartments and rations. Applications to S. J. Leonard, Clerk.

Hospital for Sick Children, Newcastle-on-Tyne.—Male Resident Medical Officer. Salary £100 per annum, with board, lodging, and laundry. Applications to Alf. E. Birch, Secretary, Secretary's Office, Hospital for Sick Children, City Road, Newcastle-on-Tyne.

Lincoln Lunatic Hospital.—Assistant Medical Officer. Salary £100 per annum, with board, &c.—Applications to the Medical Superintendent, The Lawn, Lincoln.

North Cambridgeshire Hospital, Wisbech.—Male Resident Medical Officer. Salary £125 per annum, with furnished rooms, attendance, coals, gas, and washing. Applications to William F. Bray, Secretary, Wisbech.

Preston Royal Infirmary.—Senior House Surgeon. Salary £100 per annum, with board, lodging, and washing, &c. Applications to Walter Davies, Secretary, 5 Winckley Street, Preston.

Royal Infirmary, Bradford.—Salary £100 per annum, with board and residence in the Infirmary. Applications to Edmund Forster, Secretary.

Sheffield Union Hospital.—Resident Medical Officer. Salary £100 per annum, with apartments, rations, and the other usual allowances. Applications to Albert Edward Booker, Clerk to the Guardians, Union Offices, Westbar, Sheffield.

The Cambridgeshire, &c., Asylum.—Second Assistant Medical Officer. Salary £120 per annum, with board, lodging, and attendance in the Asylum. Applications to T. Musgrave Francis, Clerk to the Visitors, 18 Emmanuel Street, Cambridge.

University of Manchester.—Junior Demonstrator in Physiology.—Salary £100 per annum. Applications to the Registrar.

West Bromwich District Hospital.—House Surgeon. Salary £100 per annum, with board, residence, and washing. Applications to the Honorary Secretary, T. Foley Bache, Esq., Churchill House, West Bromwich.

Appointments.

BIRCH, CHARLES, M.R.C.S., L.R.C.P.Lond., Medical Officer to Clayesmore School, Pangbourne, Berks.

CURTIS, WILFRED, L.R.C.P. and S.Edin., L.F.P.S.Glasg., Medical Officer for the Sixth District by the Liskeard (Cornwall) Board of Guardians.

DOUGLAS, CARSTAIRS C., M.D.Edin., Extra Examiner in Medical Jurisprudence and Public Health in the University of Aberdeen.

GAINER, J. W., M.B., M.S.Edin., Certifying Surgeon under the Factory and Workshop Act for the Thrapston District of the county of Northampton.

GOYDER, F. W., M.B., B.C Cantab., Honorary Assistant Surgeon to the Royal Infirmary, Bradford.

HODGE, R. F. VERE, M.B., B.C.Cantab., Resident Medical Officer for the Out-patient Department of Queen Charlotte's Lying-in Hospital.

HUSTLER, G. H., M.B., Ch.B.Leeds, Assistant House Surgeon at the Royal Devon and Exeter Hospital, Exeter.

IRVING, HAMILTON, M.B., B.S.Lond., M.B., Ch.B.Manch., House Surgeon at the Evelina Hospital for Sick Children.

KILVERT, JOHN ELLIS, L.R.C.P.Lond., M.R.C.S., Honorary Surgeon to the Derbyshire Royal Infirmary.

KIRKNESS, W. RONALD, M.R.C.S.Eng., L.R.C.P.Lond., House Surgeon and Assistant Secretary to the West Herts Infirmary, Hemel Hempstead.

MACLAGAN, P. A., M.B., B.S.Edin., Certifying Surgeon under the Factory and Workshop Act for the Ayton District of the county of Berwick.

MARSHALL, H. F., M.R.C.S., L.R.C.P.Lond., Assistant House Surgeon at the Evelina Hospital for Sick Children.

MORTON, A. STANFORD, M.B., M.S.Edin., Ophthalmic Surgeon to the Italian Hospital, Queen Square, W.C.

Births.

LEWIS.—On July 21st, at Nantile, Bickley, Kent, the wife of C. E. M. Lewis, M.D.Cantab., of a son.

Marriages.

HARRIS—MAYNE.—On July 21st, at St. Peter's, Cranley Gardens, London, Wilfred Harris, M.D., of 61, Wimpole Street, London, to Miss Mabel Mayne, daughter of the late Rear-Admiral Mayne, and niece of Sir Alfred Dent.

MACKENZIE—MORGAN.—On July 18th, at St. James's, West Ealing, Dudley Macdonald Mackenzie, M.D., to Constance, youngest daughter of Captain Morgan, "Belmont," Creigian.

TIBBITS—HARGREAVES.—On July 19th, at St. Mary's, Dover, Edward, eldest son of the late Edward Thomas Tibbits, M.D., of Bradford, Yorks, to Myra Lilian, eldest daughter of William Henry Hargreaves, J.P., of Christchurch, N.Z.

Deaths.

BRAYE.—On July 20th, at Hurstmonceux, King Edward Road, South Hackney, Hardwick Hubert Braye, M.R.C.S., L.S.A., aged 61.

NOBLE SMITH.—On the 20th inst., at Queen Anne Street, W., Noble Smith, F.R.C.S.Edin., aged 59. Funeral at Kensal Green on Wednesday, at 3 o'clock, leaving the house at 2 o'clock. Friends kindly accept this intimation.

ROBINSON.—On July 23rd, at 17, Blenkarne Road, Wandsworth Common, Thomas Frederick, youngest son of T. W. Robinson, M.D., F.R.C.S., aged 60.

STOCKER.—On July 21st, at Cheltendale, Middle Road, Westbourne, Bournemouth, Henry Charlton Stocker, eldest son of the late James Stocker, M.R.C.S., of Guy's Hospital, aged 68.

WANKLYN.—On July 19th, at the Laboratory, New Malden, Surrey, Prof. James Alfred Wanklyn, M.R.C.S., aged 73.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIII. WEDNESDAY, AUGUST 1, 1906. No. 5.

NOTES AND COMMENTS.

The Local Government Board Speaks Out.

THERE are many local authorities which, animated we trust by an enthusiasm for domestic economy, seek to subserve that end by the penny-wise-pound-foolish policy of cutting their medical officer's salary. Of such is the Corporation of Ashton-under-Lyne. Proceeding some months ago to appoint a medical officer of health to succeed the late Dr. Hughes, they fixed his salary at the princely sum of £80 a year, and elected Dr. Talent to the post. The Local Government Board, with commendable regard to the real interests of the town, refused to sanction the appointment on the ground that the salary was inadequate for the duties attaching to the post of medical officer to a place of the size of Ashton-under-Lyne. But the Corporation proved obdurate, and the matter is still hung up. It should be obvious to the most cheese-paring intellect that it is impossible for a salary of thirty shillings a week to expect an able and experienced man to pay all the attention which modern hygiene requires to a town such as Ashton. Solomon in all his wisdom would have been unequal to the task. Whether in consequence of not having a medical officer or not, an outbreak of small-pox is now playing through the town, whilst the Corporation is engaged in correspondence with the Local Government Board. We hope Mr. John Burns will stand to his guns.

Sir J. Sawyer and Diagnosis.

AT the annual meeting of the British Pharmaceutical Conference held at Birmingham last week the members were officially welcomed by the Lord Mayor at the Council House, Sir James Sawyer appearing as local representative of the medical profession, In his introductory speech Sir James Sawyer is reported to have said that "the medical profession had well-nigh perfected itself in the diagnosis of disease, and in the scientific knowledge of the precise conditions under which disease existed," but that it had to "recognise that it was the treatment of disease that was lagging behind." We confess to such astonishment at reading these remarks that we can only believe Sir James Sawyer to have been wrongly reported. No one will deny that the treatment of disease has not kept pace with improvement in means of diagnosis. and that it is still in an elementary and unsatisfactory condition. But to speak of diagnosis as "well-nigh perfect" is to use the language of hyperbole, and we cannot believe that any practising physician can have made any such statement.

A Horse of Quite Another Colour.

THE correspondent of a London evening newspaper, writing under the pen-title of "M.D.," puts a pertinent question regarding a recent action to recover damages from a medical man who had communicated scarlet fever to a patient. Reversing the parts of the drama, he asks what damages can be claimed for a medical man who takes an infectious disease from a patient? What is sauce for the goose should surely be sauce for the gander. But "M.D." is not content with merely throwing a brilliant idea into the arena of public discussion and leaving it to its fate. He supplies at the same time a legal principle of liability in the light of which the matter may be reasonably considered. "Where a medical man," he asks, "has undoubtedly caught, say, scarlet fever, from a patient, could the latter be sued for damages by the medical attendant under the Employers' Liability Act?" While we leave that legal nut for the lawyers to crack, it must be confessed that the prospect of thus turning the tables is somewhat alluring. Many of the claims entered against medical men are vexatious actions brought by men of straw, and fostered by speculative solicitors. Perhaps the Medical Defence Union will kindly consider the case of the medical man infected by a patient's syphilis, or scarlatina, or carbuncle, or what not.

The "Coleman Case."

LAST week the final scene in what has come to be known as the "Coleman Case," took place, when the principal members of the medical profession in Dublin waited on Dr. Coleman and presented him with a resolution signed by more than thirteen hundred of his professional brethren. The proceedings, which we report in another place, consisted in short speeches delivered by the Presidents of the Royal Colleges and a reply by Dr. Coleman. Not alone those who signed the resolution of sympathy, but also the entire body of medical men in Ireland, may be taken as sympathising with him in the grievous trial through which he has passed. We trust that, now the medical profession has made clear the esteem in which they hold Dr. Coleman's personal, as well as professional, character, those members of the

public who are only too ready to impute evil will refrain from attempts to besmirch one who has been justified by the verdict of judge, jury, and professional brethren.

LEADING ARTICLE.

SWEATING AND THE PUBLIC HEALTH.

OF the many branches that belong to medical science it would be hard to imagine one more essential to the general safety and progress of the community than that of public health. In season and out of season its activity is untiring, and it is ever covering fresh ground in its struggle towards the ideal of universal health if not of universal happiness. Looking back on past achievements, it may point proudly to lessened mortality and to increased longevity. With even greater self-congratulation can it boast of plague and cholera banished from the shores of the United Kingdom, and of typhus and small-pox fast disappearing into the same region of exile. In addition to direct tangible results, however, the public health is concerned with many things of a vastly diverse and manifold nature. To prevent preventible disease and death is its dominant end and aim. In following up that attempt it has to become acquainted with the life environment of all sorts and conditions of men, and to avail itself of all kinds of scientific and social knowledge. In the field of labour the services of the sanitarian are called into constant requisition. Inasmuch as the working-classes form the greater part of the population, their physical well-being and the national prosperity must necessarily be connected in the closest of bonds. Labour legislation aims at the regulation of the conditions of employment so as to maintain a proper standard of health. Scientific medicine is concerned with many matters, as, for instance, the length of working hours, the employment of children, sanitation of mines, workshops and factories, and the control of "dangerous" trades. It should be noted that the share of created wealth which goes to labour in the shape of wages is left by the State to be determined by natural economic laws. At the same time, it may be pointed out that improved wages have in nearly all cases been due to the concerted action of labour organisations. In sharp contrast to the fair wages of most industrial occupations where combination of the workers is an accomplished fact, may be set the pitiably inadequate pay of the disorganised and unorganisable host of persons who toil in their own homes. The tendency is for employers to cut down wages below subsistence rates, and the "sweated" toilers have to work unduly long hours, often under bad sanitary conditions, for pay that is scandalously unfair. The recent Sweated Industries Exhibition held in London showed that Hood's "Song of the Shirt" applies to-day to many a wretched seamstress, and that the greed of the sweater extends to many industries beyond shirt-making. With this state of affairs the medical profession is closely concerned. Medical practitioners visit the homes alike of rich and poor, and know as no other men know the inner life of the community. They realise that the conditions of sweated labour predispose to disease and premature death. Modern medicine recognises the supreme importance of the resistance of the individual to the inroads of disease. In the half-starved outworker resistance is feeble, and he offers a ready prey to many infections, such, for instance, as that of tuberculosis. It is not too much to say that a great proportion of the applicants to the dispensaries, hospitals and other medical charities of our towns are drawn from the sweated home-workers. The evil extends to the children, for they are often pressed into the service in order to make up the scanty weekly earnings. These things constitute a terrible indictment against society, and it is to be hoped that preventive medicine will enter an emphatic protest against the evil that is undermining the national life. The problem is difficult of solution, but that has been the case with many social abuses that have been successfully overcome. One of the best-informed serious attempts to to deal with the whole matter is the model Bill introduced by Mr. H. J. Tennant to amend the Factory and Workshop Act of 1901. It is impossible here to enter into a detailed discussion of the many excellent proposals contained therein. It may be stated generally, however, that it makes the employer responsible for the sanitary state of the outworkers' homes, and provides for inspection. It is obvious that Parliament will be chary of interfering with the house of the Englishman. In the case of factories and workshops, however, the State has asserted its right of control, and it is surely not illogical to seek to extend that supervision when the scene of the labour is shifted to the homes of the workers, for the public health must now be the object of supreme solicitude. In conclusion, we advise all who are interested in this important subject to make a careful study of Mr. Tennant's Bill.

NOTES ON CURRENT TOPICS.

The "Normyl" Treatment Again.

IN the *Daily Mail* of last Thursday appeared an article by the Rev. Hugh B. Chapman on the results of the first year's working of the "Normyl" treatment under the auspices of the Normyl Treatment Association, and as some remarks we made a little time ago were replied to by Mr. Chapman we feel that we must not allow his criticisms to go unanswered. We said at that time that it was "not easy to accept the statement of the Secretary that no pecuniary profit is obtained from the sale of the medicine." Considering that three guineas is charged for the "medicine" we were pretty safe in making that statement, and Mr. Chapman lets the cat out of the bag by saying that "we have always said that a royalty is paid to Mr. Hutton Dixon." Quite so; we do not assume that Mr. Chapman

himself is anything more than a benevolent clergyman, but that he and his Association are the cat's-paws of an astute tradesman is evident to observers as well versed in the ways of quackery as ourselves. Let us assure Mr. Chapman that we have seen a good dozen of these "treatments" for alcoholism brought out, flourish, and disappear with the regularity of the stars in their courses, and that without benevolent clergymen like himself and Canon Fleming the profits of their promoters would be considerably less than they are. During the past year Mr. Chapman tells us there have been 1,650 "treatments"—we presume he means 1,650 patients under treatment—and that "the failures *that are known to us* (the italics are our own) do not amount to as many as 8 per cent. of the total number of treatments." Surely serious criticism of figures thus presented is hardly called for. We know nothing of the "state on admission" of the persons treated, but we do know how human nature is liable to persuade itself that a "treatment" is necessary even if it is not very ill, and we also know from Mr. Chapman that in some 120 cases the treatment has failed within a year! And if Mr. Chapman knows of 120, how many more are there, we wonder, that he does not know of? Mr. Chapman defends the principle of secrecy with regard to this remedy because he does not see "why the inventor should be asked to sacrifice the honourable results of his labour." But it seems to us that Mr. Chapman *does* see why he (Mr. Chapman) should sacrifice the honourable results of his own labour, as he is giving his services free in the cause of this treatment! Can he, we wonder, apply the argument? And is it too late for him to see the force of its application?

Forceps in the Abdomen.

Some two or three years ago a great outcry was raised because a well-known surgeon, after a long and tedious operation, had left a pair of artery forceps in the abdominal cavity of a patient. The accident is one which, theoretically, never should occur, but while human nature remains fallible it is to be feared that it cannot reasonably be expected that it will not happen again, any more than that no railway train will ever come to grief or that no motor-'bus brake will ever fail to act. But serious as is the overlooking of a pair of forceps, the occurrence does not always, or even necessarily, lead to a fatal termination. A case has recently been reported from Perth, West Australia, which strikingly illustrates the possible harmlessness of such an accident. A woman who complained of certain abdominal symptoms was thought by her medical adviser to have an abdominal tumour, but when she was examined by Rontgen Rays what appeared to be a pair of scissors was seen in the site of the swelling. The abdomen was therefore opened, and to the astonishment of the surgeon a pair of artery forceps which must have been there for eleven years was discovered. The forceps were removed, the abdomen closed, and according to the last report the woman was out of danger and making good progress towards recovery. This case shows then that the leaving of instruments in the abdomen is not such a serious accident as is popularly supposed, but it is nevertheless an occurrence that cannot be too carefully guarded against.

Snobbery in Army Nursing Service.

We have read in the *Army and Navy Gazette* certain charges of a grave character against the management of the Army Nursing Service as at present constituted, charges which even now we hesitate to accept without full evidence. The new Nursing Board, like all new brooms, it seems, wishes to sweep clean, and in the pursuit of this policy it has started by weeding out the old nurses. If the old nurses were bad, of course it would be impossible to say anything unless actual injustice were perpetrated; but it is stated in our contemporary that a young woman, although in every way a good nurse, was "hunted out" of the Service for no other reason than that her father was a non-commissioned officer. *The Army and Navy Gazette* says it can produce other and even more flagrant instances of this policy, and says that other nurses who have done good service at home and abroad have received their *conge* from the Nursing Board. The worst feature of the case is that the nurses seem to have no appeal and no means of redress; one nurse took her case before the High Court, but lost it, as no action can lie against the Crown. We feel sure that our contemporary would not make these statements without having satisfied itself as to their soundness, and we thoroughly agree with it that an impartial committee ought to be appointed to investigate these "reductions." In any case the nurses are likely to have the full support of the medical profession, which has suffered so much in the past from snobbery in the Army.

The Manufacture of Paupers.

We have preached for so many years in these columns on the text of hospital abuse that we may be permitted some satisfaction in observing that the matter is day by day attracting wider attention. Hospital "charity" administered to the undeserving is the very opposite of mercy; it curseth him who gives and him who takes. It robs the needy and deserving poor of the help intended for them; it robs the benefactors by diverting their gifts to improper uses; it robs a hard-working and ill-paid profession of their legitimate earnings; and it robs the recipient of his independence and energy. Our readers do not need to be told that in all the great cities of the Kingdom, but particularly in London, hospital administration has almost become a scandal by its carelessness in the discrimination of suitable objects of relief. It is satisfactory, however, to find that this knowledge is gradually permeating the public mind, since only from public pressure can we hope for reform. The *Spectator*, least sensational of papers, has recently devoted an article to the manufacture of

paupers by hospital relief, and we cannot do better than quote a sentence:—"There is a large body of thoughtful and experienced people who think that medical relief as it is now administered in London, more particularly through the out-patient and casualty departments of our voluntary hospitals, and through the free and part-pay dispensaries, is a frightful source of evil, inasmuch as it is to a large extent a waste of energy and material, and is a means of pauperising the recipients."

The Newspaper Press and Quackery.

ON another page we print the judgment of the Scotch Court of Appeal in the "Bile Beans" case. None of our medical readers can need any more light upon the subject, and we give the news for the benefit of our lay contemporaries. Not a single English newspaper has published any notice of the case, much less any comment upon it. Almost without exception they have had a share of the fabulous sums which were shown at the first trial to have been expended during the past few years in advertising "Bile Beans." The newspaper press, from *The Times* downwards, is showing that where consideration for the welfare of the public clashes with their sordid interests the latter are to be preferred. That the distinguished and wealthy proprietors of great London journals—they include at least three peers of the realm and several baronets—should, for the sake of gain, lend themselves to a discreditable traffic is deplorable. When the whole hideous story of the cruelty and fraud of medical quackery is disclosed to the world, a proper share of the shame and the blame will surely fall upon the noblemen and gentlemen who own the newspapers by the help of which the quacks find their victims.

The Management of Lunatic Asylums in Ireland.

As was to be expected, the Chief Secretary for Ireland was attacked by several Members in the House of Commons on Thursday last on account of the action of the Local Government Board, to which we alluded at length in our last issue. As we read the speeches of these gentlemen we fail to see that any reason for taking and handing the control of Irish asylums from the Medical Superintendent over to the Chief Clerk was brought forward, save the plea that the committees of certain asylums desired the change. We have, on the other hand, nothing but praise for Mr. Bryce's reply, which was as follows:—"Mr. Cogan has presented a totally different view of the Richmond Asylum dispute from that within my own knowledge. I myself intervened in the matter, and a compromise was effected on all but one point. It was an important point of principle—namely, whether the responsible officer of the Asylum should be the Clerk or the Resident Medical Superintendent. The Board thought it should be the latter, while the Richmond Committee held that it should be the Clerk. Medical opinion supported the Board's view, as did the large majority of the Asylums Committees in Ireland. I myself believed that the Board had done right." It will thus be seen that Mr. Bryce's speech entirely supports the statements made in the "special article" which we published last week on this important subject.

Channel Swimming.

THE channel swimming season has set in with its usual severity. The arm of the ocean, so dear to adherents of the blue-water school, which separates Great Britain from her nearest ally, is dotted with seekers after immortality, and the London Strand is dotted with placards describing their adventures. If Englishmen, as a rule, take their pleasures sadly, there are a few at least who take them strenuously enough to please even President Roosevelt. The medical philosopher cannot help asking himself what effect this Channel ploughing enthusiasm has on the health of those individuals who indulge in it at the moment, and of those who may be stimulated to do likewise in the future. Given a man of well-knit frame, sound organs, and long training by sea and land, it is just possible that he may come through the ordeal of an eighteen or twenty-four hours' swim without permanent damage; but such cases must be exceptional. Apart from the immediate dangers attaching to conditions of fatigue and chill, there is the other and greater one of life-long impairment of vital organs. The continued congestion of the viscera, produced through the chilling of the body-surface by sea-water is liable to produce insidious structural change in the kidney, and the violent muscular exertion of swimming without rest for many hours cannot but strain the heart terribly. We are prepared to congratulate the first successful emulator of Captain Webb's feat, but rather on the score of his pluck than his prudence. And to any who may be contemplating the task we would proffer the advice given by a contemporary to readers about to embark on a less perilous, but more commonplace undertaking—"Don't."

The Eton Slouch.

IN a recent volunteer inspection address at Eton College, General Oliphant took the boys to task for their "slouching" gait. What with one general preaching conscription and another universal drill, it looks as if the whole nation were slipping under the iron heel of militarism. When soldiers try to force their foolish ideas as to smartness of bodily carriage upon our schoolboys, it is indeed time for medical protest. Briefly put, the puffed-out chest and the stiffness of gait suggestive of a ramrod down the back are grotesque, unscientific, and defiant of the laws of common-sense no less than of physiology. The well-built athlete has a slight forward curve in the neck and the upper part of the back, and his chest is flat rather than otherwise, especially when not under strong exertion. May Heaven forefend that our public schoolboys, who are for the most part in

the pink of training and bodily activity, should ever be brought to regard the martial strut as a better way of walking than their own free and easy, but withal graceful, slouch! It is all very well for soldiers to assume a swagger as if they were the salt of the earth. They may be excused the assumption as members of a profession that cultivates blind obedience to discipline at the expense of individual initiative and energy. The plain unassuming public schoolboy has, happily, a way of slouching into control of the world's affairs in all directions, intellectual or physical, in a field that extends far beyond the range of the small section of the community that constitutes the British Army.

"The Redemption of the Inebriate."

In our leading articles of May 23rd and July 4th we described and analysed the series of puffs of the Keeley Institute headed, "The Redemption of the Inebriate," which during the past few months has been published in *The Times*. This examination was not necessary for medical readers. None of these could fail to recognise what were the real claims to consideration possessed by this philanthropic institution where patients are received only on payment of twenty-four guineas in advance for four weeks' treatment. We clearly explained several chief reasons, each sufficient in itself, and suggested many minor ones why these advertisements ought never to have been printed in such a form, bearing the endorsement of the leading journal; and particularly we pointed out that the puffs constituted a gross reflection upon our profession. These full explanations were given for the benefit of the proprietors and managers of *The Times*. We were willing to suppose that these gentlemen were not aware of the character of the business in which they were assisting; and we hoped that, being informed, they might withdraw from it. The series of puffs has, however, been continued. One is printed in the issue of July 25th, and we are promised another in August. We are told further that "The observations and conclusions of the independent medical practitioner engaged upon this investigation will form the subject of the next announcement." This announcement will be awaited with some special interest, since the name of the independent medical practitioner will then, no doubt, be disclosed for the information of the profession and the General Medical Council.

The Cardiff Asylum's Appointment.

On July 25th the Cardiff City Council met for the second time to consider the appointment of a medical superintendent for their asylum. The circumstances attending the first meeting have been already commented on in our columns, and were the subject of much local feeling. After interviewing the candidates, the Council proceeded to the election, and Dr. Goodall, superintendent of the Carmarthen Asylum, was chosen for the post. It is significant that Dr. Goodall's name was not on the "short list" at the previous meeting, and the protests that were entered at the time seem to have been fully justified.

PERSONAL.

Dr. Robert Jones, president-elect of the Medico-Psychological Association of Great Britain and Ireland, entertained the council of the Association at dinner at the Reform Club on July 25th

Dr. Emil Fischer, Professor of Chemistry in the University of Berlin, was presented with the honorary degree of D.Sc. at Manchester last Saturday. Professor Fischer's researches on the synthesis of the sugars and of proteids has placed him in the front rank of scientific investigators in Europe.

The name of Dr. Muir Smith has been added to the commission of peace for the borough of Eastbourne. Dr. Muir Smith is a well-known supporter of the Liberal cause in his neighourhood.

Mr. C. K. Darnell, of Bangor, was presented on July 17th, with a piece of silver plate, a congratulatory address, and a cheque for three hundred guineas by a number of medical sympathisers.

A number of his admirers are arranging to present Sir Henry D. Littlejohn with his portrait. Many of Sir Henry's old pupils will doubtless be glad of the opportunity of subscribing.

Lieut.-Colonel Skinner, Secretary to the Advisory and Nursing Boards at the War Office, has had the decoration of the Fourth Class of the Royal Victorian Order conferred on him.

Mr. Charles A. Ballance, of St. Thomas's Hospital, has also been appointed a member of the Royal Victorian Order.

It is with great regret that we record the death of Dr. Brouardel, perhaps the best-known French medical publicist.

By the death of Mr. Beit the London University Hospital of Medical Sciences becomes entitled to a legacy of £25,000. By the same event the King's Hospital Fund and Guy's Hospital both benefit to the extent of £20,000.

The will of Dr. James Steward, of Castlerock, Londonderry, and of Ballarat, Australia, has been sworn at £135,604. Dr. Steward left the princely sum of £50,000 to be divided among the Irish and Australian charities.

The first number of the most important work on birds that has appeared for many years has just been issued. It is entitled "The Birds of the British Islands," and is written by Mr. Charles Stonham, C.M.G., F.R.C.S., of Westminster Hospital.

In the list of new officers of the Legion of Honour published last week, the name appears of the Hon. Alan Percy Molyneux Herbert, M.D., uncle of the Earl of Carnarvon, and one of the oldest and most respected members of the English colony in Paris.

The medical officer of health for Birmingham told the Chemists' Conference in that city that out of twenty-seven samples of camphorated oil bought for analysis thirteen were more or less adulterated; and one sample of seidlitz powder "guaranteed to be pure contained only one third of the right amount of Rochelle salt.

A CLINICAL LECTURE
ON THE
TRANSMISSION OF SYPHILIS TO THE THIRD GENERATION.

By JONATHAN HUTCHINSON, LL.D.Oxon., Hon.M.D.Dub., F.R.C.S., F.R.S.,
Consulting Surgeon to the London Hospital, the Hospital for Diseases of the Skin and Royal London Ophthalmic Hospital.

GENTLEMEN,—The subject of my lecture to-day is the question of the possibility of the transmission of syphilis to the third generation. There is often a little misconception as to what is meant by the second and third generation, and I think we shall avoid that best by speaking of first heredity and second heredity. The facts as regards first heredity are well known, well established. So recently as the time of John Hunter, it was not believed that syphilis could be transmitted to the offspring. That view was held by some, and an opposite view by others, but many of the acutest thinkers on the subject were sceptical as to whether syphilis could be transmitted to children at all. None of us has any doubt upon the subject now. We know that a certain number of children, born of syphilitic parents, inherit the disease and manifest it in very well-known ways. It may be well to examine a little as to the fact of that inheritance, before we come to discuss the question as to whether there can be any second inheritance.

I think there is very great justification for believing that recently the parasite which causes syphilis has been discovered. That discovery merely gives to us increased demonstration of what we formerly believed. We have inferred, within the last half century, that there must be a specific living parasite which causes syphilis, just as we know there is a specific organism for small-pox, and another for measles, and so forth. And we have got so far as this: We have collected evidence as to the duration of the life of this specific vital organism which gives rise to syphilis, and have come to the conclusion that within two years after having been infected by it—probably within a much shorter period, even within two months—most patients who have contracted syphilis are free from the disease, in the sense of being liable to infect anyone else in any way whatever, and that there is then no danger of their producing syphilitic children. For instance, some fifty years ago a man was allowed to marry as soon as the secondary symptoms had completely disappeared—two or three months after having contracted syphilis—as it was at that time believed by most medical men that such a person was not liable to infect his wife or to produce syphilitic children. Since then we have learned that syphilitic infection may certainly extend over nearly two years. The possibility of a man infecting his offspring or his wife, or both, may last for that time. The spirochæte may live in his blood during a period of two years, and so long as it is living in his blood so long may he transmit that spirochæte to anyone, whether by inoculation or by contact. In order to determine whether the spirochæte is still living in the blood of a patient, you must examine the syphilitic lesions of either primary or secondary syphilis.

If you examine the patient in the tertiary stage of syphilis he is still liable to certain symptoms which result from the presence of the spirochæte previously, but which are totally different from those produced by its actual presence. We will say, then, that there is good evidence for believing two years to be the limit of the life duration of this syphilitic parasite. I have for long been accustomed to allow patients to marry at the end of two full years, irrespective of what their symptoms may have been, whether slight, or severe, or still persisting, or not. If, at the end of two years, a patient is still under treatment for syphilis, I should be still more confident that he could not infect his wife or transmit the disease to his children. I have let hundreds of such patients marry, and they have never come back to me in consequence of having infected their wives, or of having syphilitic children. If there were any cases in which they were disappointed with my advice I did not hear any complaints, excepting, perhaps, in one or two instances, and, as I say, these are exceedingly rare. So that I think I am justified in saying that the average duration of the contagious period of syphilis is about two years. This has a very important bearing on the question as to the possibility of the transmission of syphilis to the third generation, because a period of about twenty years must elapse before a child of syphilitic parents becomes a parent himself, or herself.

But there is another kind of evidence which we have investigated with great interest, evidence as to the events which happen to the children of parents who have married too soon—say, within the first year after one or the other, or both of them, had contracted the disease, or six months before the parasite had died in the blood. We have collected a very large amount of evidence as to that, and we know that if a syphilitic patient marries within the dangerous period and syphilitic children are born, then the first, and perhaps the second and third and fourth earliest births may suffer from the disease, but the later members of the family, if it numbers six, or eight, or ten children, are perfectly free from taint and show no evidence of infection. Many family histories of that kind have been published.

I would introduce a little matter of detail here and say that there are cases in which three or four first-born members of a family suffer from syphilis, and the family history gives a considerable number of abortions as having occurred. This will be regarded by some authorities as proof that the possibility of begetting syphilitic children lasts much longer than I am implying. There are, however, plenty of cases in which the first-born, and perhaps the second, suffer from syphilis, but, it is not inherited syphilis; it is the disease in its

Lecture delivered at the London Hospital, June 12, 1906, being the first of a series of four lectures to appear consecutively in this Journal.

acquired form, and the definite and ordinary symptoms of inherited syphilis are quite distinct from those which are present when the disease has been acquired. So that I think we are justified in believing that the period during which syphilis may be transmitted to children of the first generation is a comparatively short one.

But I believe that it makes a considerable difference as to whether the syphilis is inherited from the father or the mother. There is no doubt whatever that syphilis may be inherited from one or the other parent, but, in English practice, the great majority of cases of infantile syphilis are of paternal inheritance. Comparatively seldom do we meet with cases in which the mother was the one who suffered from syphilis. But I believe that the possibility of transmission lies very much longer in the woman than in the man. If a woman has had syphilis, the virus may be stored up in her ovary very much longer than it is likely to remain in the semen of the man. Hence, whenever transmission of the disease occurs after a very considerable period subsequent to marriage, and in cases where alternate children may suffer from syphilis, it is almost always the mother from whom the disease has been inherited. The paternal inheritance does not last long; a year or two is the limit of it, and, afterwards, provided that the woman is not affected with the disease, the children born are free from all taint.

It is said, especially by some French authorities, that syphilis in transmission is not always what they call virulent syphilis—that is, syphilis in which the child is sloughing and has the characteristic rash and other symptoms of pronounced syphilis; but the child inherits some sort of debility, or what is now termed dystrophy—some derangement in the nutrition of some part of the body, due to syphilis but not exactly syphilis. This French school speak of these dystrophies as presenting a great variety of symptoms, including rickets, deafness, deformities of the eye, club-foot, and even harelip. My own belief is that there is no reasonable probability that the majority of what are called dystrophies have any connection at all with syphilis, but that they occur quite accidentally and are just as common in populations into which no syphilis has ever been introduced as they are elsewhere. I believe that syphilis produces itself, or produces nothing. If the disease is transmitted the child must have its rash and infantile symptoms, and these symptoms, however slight or severe, must occur within three months of life. These are cases in which we must suppose that the specific spirochæte has actually gained access to the child's tissues, that the child has inherited the spirochæte and all that that organism is capable of doing. Either the spirochæte is present or else there are no symptoms; and, as I have already said, I do not believe that the tertiary symptoms, those symptoms which may be present after the spirochæte has perished, are capable of being transmitted.

I am going to discuss the probability of secondary inheritance. But we have, first, to ask, What are the conditions of primary inheritance? Primary inheritance is, after all, a very limited thing; it lasts a very short time. Is it in the least probable, then, the conditions of primary inheritance of syphilis having died out, that the disease will recur after any prolonged period? In most of the cases in which it is asserted that parents who had suffered from inheritance caused the disease to be inherited again, the evidence goes to show that the symptoms upon which the observer relied, in the secondary inheritance, were the ordinary ones; the child was born having snuffles and the ordinary phenomena. Now, if two parents, having both had syphilis, cannot transmit it over a period of a year or two, is it likely that the disease will show itself in their children ten or twenty years afterwards? I want to say it is improbable in the highest degree that such a thing should happen. Of course, improbability is not impossibility and does not disprove the fact; but when improbability is exceedingly great, then we have to look at the evidence and scrutinise it carefully before we allow our minds to relapse into a position of credibility. I think it is exceedingly improbable that there should be any secondary inheritance of syphilis, because the parents are then at a very distant period from the acquisition of the virus, and the virus does not last long. Supposing, however, that a patient, now an adult, had, as an infant, inherited the disease from his parents, and that he still possessed the virus in his blood, might he not transmit it by a scratch or accidental inoculation? We get no cases at all of supposed accidental inoculation from those who are the subjects of inheritance. But there is an interesting point in connection with vaccination. It is perfectly possible to transmit the virus in the circulation, and for that purpose a few blood corpuscles, taken from a patient who has the virus, would be quite sufficient. We have investigated a certain number of cases in which a series of children, a batch of fourteen or fifteen, inoculated from the same patient, all acquired syphilis. But all the cases in which that has occurred are cases of vaccination from an infant who has had syphilis, and not from older patients; and they were cases of arm to arm vaccination direct. Moreover, I never heard of an accidental case of syphilis attributed to contact with a subject of inherited syphilis, after the infantile period. If, in adult life, people who had as infants inherited syphilis were virulent subjects of the disease we should have syphilis very much more common than it is. That, again, is very strong evidence in favour of the belief that a patient who has grown up to adult life, and had syphilis in his infancy, is no longer the subject of the disease in its transmitable form. He is liable to keratitis, but it is a mistake to think that a patient still has the virus in his body if he can get an acute attack of keratitis. I hope that very soon, by experiments of inoculation, we shall be able to show quite definitely that, at the age when patients suffer from keratitis, they are not infective at all as regards the transmission of syphilis. All the evidence that we have at present on the point goes to prove that keratitis occurs after the syphilitic virus has ceased to be present, and is merely a consequence of what the virus has done to the cornea.

Now we come to the examination of evidence which has sufficed to convince many excellent observers that secondary inheritance does occur, and a number of cases have been collected as proof that even third inheritance of the disease may take place. These cases must, I submit, be investigated with much circumspection, or else they will not carry conviction. Nothing

amazes me more than to read statements published on the Continent, especially in France and Russia, as to the great number of cases which medical men there have seen illustrating this and that fact. I have been on the careful look-out for at least half a century, and have been in a position where my friends would, I am perfectly certain, have sent me any rather exceptional cases which appeared to refute the views that I am expressing to you now. As they have not done so, I must infer that they have no personal knowledge of any case having occurred illustrating the transmission of syphilis to the second inheritance. Therefore, I cannot see how these cases reported on the Continent can be cases of secondary syphilis. I could count upon my fingers the cases I have collected which were supposed to be cases of secondary inheritance.

It will be valuable, I think, just to go into a little detail as to cases that I have published of women, all of whom had inherited syphilis, but were, nevertheless, the mothers of healthy children. In one case the woman was forty-seven years of age, and was very evidently herself suffering from taint. She had six children, but none of these children suffered from any syphilitic symptom whatever. They appeared to be quite healthy, with the exception of one child who was the subject of a diseased hip. This affection would be claimed as a dystrophy in connection with inherited syphilis; but is there any probability that a diseased hip in a child had any special connection with inheritance from a mother who had suffered from syphilis?

Another case is that of a woman who informed me that she had three healthy children, and that none of them had ever suffered in infancy. I had no opportunity of seeing that they were perfectly healthy, but this woman was transferred to me by a colleague as being an interesting example of the results of inherited syphilis. She had a sunken nose and other characteristic symptoms of syphilitic taint.

Another mother who had suffered from inherited syphilis had a large family of children, but none of them had suffered from the disease, though several of them were delicate. There again are dystrophies, if you like, but there are plenty of delicate children who have not had syphilis. This woman's husband had died of decline, and there you have an obvious reason why her children might be delicate, without their having inherited any syphilis from her.

In another case a woman who had inherited the disease was the mother of children, none of whom had any inherited symptoms.

Now for two cases which looked as if there was inheritance. A woman came to me at the hospital, on July 22nd, 1862. She was obviously a subject of inherited taint, and had come to the hospital suffering from an attack of interstitial keratitis. She was married and had one child, and told me it was perfectly healthy. She brought the child, and on examination I found that it was very obviously suffering from syphilis. This was not a case of dystrophy; the child had snuffles and rash. I asked the mother whether she had had syphilis within the last two years, and she said she knew nothing of having contracted syphilis at all. I got her to send her husband up, and I asked him if he had suffered from syphilis. He said he believed he had had the disease. Though I could not write down definite proof that this man had been a subject of syphilis, yet I think it is exceedingly probable he had. There are many people who contract syphilis before marriage, and it is very possible that this man might have had it.

In my next case the evidence showed that the patient had really inherited secondary syphilis. In that instance a woman brought her child to the Polyclinic, for demonstration, as a subject of inherited syphilis. The case was unquestionably one of syphilis, all the ordinary symptoms being present. I also examined the mother, and there was no doubt that she herself had suffered in infancy from inherited syphilis. I asked to see her husband, and on being questioned, he denied having had syphilis. There was nothing about him which would justify my saying that I did not believe his testimony. The woman entirely denied having suffered from any symptoms during her married life. I said to the woman, "I wish you would come up to my house, and let me examine you further." She did so next day, and then, when I asked her if she had had any eruption the truth came out. She said, "Yes, I attended University College Hospital for sores soon after my marriage." "How long after?" "Several months." On asking what medicine she was given there, she said that they gave her pills for three months, soon after her marriage. There you see the fallacy at once. The probability is exceedingly great, amounting practically to a certainty, that this woman had been infected with syphilis by her husband. So that there was no proof whatever that the attack of syphilis from which this woman's child suffered was a case of transmission of the disease to the third generation. These are fallacies which attend almost all cases that are supposed to have inherited secondary syphilis.

I have an interesting paper by Dr. Marshall, a very able man, who accepts evidence that I should be very unwilling to consider conclusive, on the question of the transmission of syphilis to the third generation. He publishes one case in which he did not examine the whole data as regards the parents. Of what real value can such evidence be? In regard to other cases he has invented, the term, "binary syphilis," meaning thereby that a patient inherits syphilis, and then contracts it on his own account. I have no doubt that a patient who has inherited syphilis may contract it, but I maintain that a patient who transmits the disease to the second generation is not transmitting what he has inherited but what he has acquired. And although, usually, it is the mother who transmits syphilis, it is possibly not the mother who acquires it. As to binary syphilis, my experience does not give me half a dozen cases that could be considered binary; and I have most diligently collected examples of syphilis as having been contracted by those who inherited it.

Some very curious conclusions have been formed with regard to binary syphilis. For instance, Trenan believes that binary syphilis is one of the principal causes of the rapid degeneration of the population in country districts. How syphilis can be fatal to the population without, first, infecting individuals, it puzzles me to see. The influence of syphilis on the population generally is very small; it is not the cause of degeneration at all.

To my mind, such a thing as secondary syphilis rests upon an extreme improbability, and upon the extreme uselessness of the evidence by which its occurrence is asserted. I think it will be scarcely possible to record a single case free from fallacies, and I am therefore an entire disbeliever in what is termed secondary syphilis.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week's issue will be by Jonathan Hutchinson, LL.D., Oxon. and Cantab., Hon. M.D. Dub., F.R.C.S. Eng., F.R.S, Consulting Surgeon to the London Hospital, the Hospital for Diseases of the Skin and the Royal London Ophthalmic Hospital, on "The Connection between Tuberculosis and Syphilis," delivered at the London Hospital,*

ORIGINAL PAPERS.

MITIN IN SKIN DISEASES.

By PROFESSOR E. SCHWARZ, M.D.,
Professor of Skin Diseases, University of Prague.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

At the last meeting of the Medical Society, Schwarz praised the efficacy of Mitin, recently introduced to the profession by Dr. Jessner and widely advertised by Prof. Nevinny. Whatever may be its future, specailists seem to be pleased with present results. Properly speaking, the unguentum base is an emulsion and not an ointment.

Schwarz said this was a new base for applying any drug to the cutaneous surface, and was therefore of incalculable value to the dermatologist. Hitherto our bases have all been composed of some form of fat from animals or plants but more recently from some inorganic substances such as shale, and may be enumerated as follow :—

Pigs Fat = Adeps Suillis	Vasogen.
Sheep skin = sebum Ovile.	Ung. Caseini
Wool fat = Adeps Lanæ or Lanolin.	Ung. Glycerini
Vaselin, Hitherto the best.	Ung. Leniens
Ung. Paraffini, a mixture of hard and soft paraffin.	Resorbin. Fetron, etc.

All these agents have now long been in use and each has its defects and merits from a scientific point of view, although each manufacturer has endeavoured to reduce the latter to a minimum. All these bodies have two defects to surmount—viz., either the constituents of the base are chemically unsuitable or the surface of the skin is too sensitive—*i.e.*, idiosyncrasy is too great for any external application. The fat of animals is excellent when rubbed in fresh, but becomes an irritant when rancid. Here the inorganic fats have the advantage, as the paraffins and vaselines do not decompose in this way, but their chemical constituents are again injurious to many skins that make them inapplicable ; hence the one is objectionable from its decomposition, the other from its chemical composition.

There is another property in a base that should not be overlooked—viz., its capacity for taking up any drug and distributing it regularly throughout its substance. If it does not admit of the drug being regularly divided, its use as a vehicle is dangerous. Its consistence is another important property of an ointment, and in this respect vaseline and resorbin have met with approbation ; but both have been objected to on the ground of acidity, as both have varying quantities.

Schwarz asks what a proper vehicle should possess ? First it should be neutral, free from all irritants, consistent, retain the drug evenly, while it preserves the skin in a normal functional condition.

The sweat and fat glands provide secretions of great importance in retaining the skin in a normal condition—the first being a serous fluid, the latter a fatty product ; the former for regulating the heat of the body, while the latter softens the skin and covers it with a protective shield in case of poisons or injury, giving an elastic consistence to the cutaneous surface after being bathed with perspiration. There is also another consideration to be borne in mind with regard to the lymph serum, which dermatologists value according to the intensity of the disease. There are other properties of equal importance, viz., suppleness of the skin and smell of an ointment, on which a patient often places value according to his sensibility ; and, lastly, the base should be miscible with other substances to make it effectual as a healing agent.

These were the points discussed with Jessner in his ointment preparation of Mitin. His first combination was with lanolin, glycerine, water and egg, in the form of emulsion, with other fats. He found a pure emulsion would not serve his purpose as the fat tended to separate from the water and rendered the application useless as a vehicle for presenting other substances to the skin. He subsequently resorted to the principle of superfatting the base with more success after a series of laboratory experiments. As milk was a product of the cutaneous glands analagous in many respects to the sebaceous product, he thought this principle ought not to be forgotten and hence obtained a product superfatted containing a large amount of fluid similar to serum.

This preparation is now manufactured in three forms—viz., mitinum purum, cosmeticum and paste. The first is combined with mercury, the properties of which have impelled me to trouble you with such a complex article of the pharmacopeia. Mitinum purum is a white, soft, inodourless neutral substance easily miscible with any other medicament, and when desirable 30 per cent. of oil may be added. To the dermatologist it is a great boon where the skin is red, broken or tender ; its action is soothing and comforting to the cutaneous surface. The mitinum cosmeticum contains more emulsified fat and serum, which fits it for a general sedative and may be slightly perfumed for this service. This paste is admirably fitted for the protection of abraded surfaces or mixing with any other substance for giving relief, such as resorcin, &c. This property has already become so stereotyped that a 15 per cent. Lenigalol paste is largely sold for general use. The practical point I alluded to was the efficacy of the mercurial preparation which is sold in 35 gramme graduated tubes. It contains 33⅓ per-cent. of mercury or 10½ grammes in each tube.

The following 25 cases were treated with mitin in one or other of the forms described (*a*) Four eczema, two healed, one improved, and one unchanged ; (*b*) one with dermatitis (Dühring) cured ; (*c*) six with acne vulgaris still under treatment ; (*d*) thirteen from Lues—two primary, eight secondary, three tertiary ; (*e*) one from Herpes zoster.

The unhealed eczema case was an obstinate surface in the armpit always bathed in perspiration, with itching and thick infiltrated raw dermis. The mitin relieved the raw surface, but owing to the itching and scratching thigenol had to be added to the paste before a cure was effected. The two cured were in the desquamating stage and yielded readily. The remaining case, a female, æt. 45, had first a discharge from the ear, which finally infected the entire body and brought the patient to death's door from the want of rest. The Mons Veneris and inguinal region were in a raw desquamating state which had become chronic. Mitin purum, generous diet, and tincture of iron was prescribed with immediate improvement. The skin is now soft and flexible, of a normal colour, without any trace of itching after eight applications of pure mitin. After two years' suffering she now sleeps and eats well.

The six acne cases were treated with cosmeticum, which was followed by a removal of the comedo. It may be noted here that mitin seemed to act as a protection against further infection. The Herpes zoster: though containing cocain the ointment failed to counteract the raw painful surface on the right side of the head.

The Dermatitis herpetiformis of Dühring requires a more detailed description. In December last H. J., æt. 50, married, and a gardener by trade, came to hospital complaining of an intolerable itching which had afflicted him for three years; otherwise he seemed to enjoy good health. On the neck and hairy parts, as well as the extremities, small white vesicles appeared with great itching, causing him to rub the surface, which became inflamed, the hair forming a hard mass. The internal organs were perfectly healthy. The back and neck were thick, raw-looking, and bleeding in parts from the constant scratching. There was a good deal of pigmentation from the long duration. After seven days' treatment the patient was greatly relieved and the red thickening had disappeared. The mitin was continued, but no new vesicles appearing the patient was discharged. Reports confirm a perfect cure.

The syphilitic cases were all treated with mercurial mitin. The first of the primary cases had a hard annular swelling with phymosis and large hard glands; the second resisted other forms of treatment. Both were put on two grammes daily local inunction with wonderful success.

The eight cases in the secondary stage had the exanthema papules in the throat and anus. Five grammes of mitinum mercuriale were applied daily. In the course of two weeks every symptom had disappeared.

In the three tertiary cases one of them suffered from a severe form of Psoriasis palmaris et plantaris; the second from a painful eruption on the breast; while the third suffered from a serpigenous ulcer on the roof of the mouth and uvula. All of them healed in a short time. In other cases of psoriasis warm bathing of the hands and feet hastened the absorption. It is scarcely necessary to praise the working of the mercurial preparations as all forms of mercury are effectual in syphilis, but the vehicle by which it is presented to the body often modifies its action and adds to the comfort of the patient. Mitin is readily absorbed and is clean. It is easily washed off without any loss of time and carefully put up in tubes of 30 grammes for immediate use, which enhances its value for practical application. One medical property which should not be forgotten by the dermatologist is its neutral quality as a necessary attribute in the healing process. Where hair is present it is easily cleaned away in inunctions and prevents folliculitis. It prevents the stomata from becoming choked and hastens the action of the drug.

In conclusion, we have obtained an ointment with all the properties so long desired by the dermatologist: to keep the skin elastic, readily absorbed, not greasy, clean, and easily removed.

HAY FEVER AND ITS TREATMENT.

By WILLIAM LLOYD, F.R.C.S.

Nose, Ear, and Throat Surgeon to the Kensington General Hospital: Aural and Laryngeal Surgeon to the St. Pancras and Northern Dispensary, &c.

THE most frequent type of periodic hay fever is that which occurs during the flowering of certain plants during late spring and summer, but some individuals suffer during any period of the year. During the warm and dry weather the atmosphere is naturally laden with a host of stimuli that do not exist in winter. Until recently this form of vasomotor coryza was believed to result from the action of the pollen of plants which, as experiments have shown, play an important rôle in the disease; but other equally important exciting causes which may induce an attack are—odours, emanations of animals, cats, dogs, horses, heat and irritating particles such as dust, ipecacuanha and the like.

It is generally accepted that there is essential to the development of vasa-motor catarrh the presence of three factors, which are classified as, first, a neuro'ic temperament; second, a hyperæsthetic condition of the terminal filaments of the sensory nerves, usually brought about by some local change; and third, the presence of some source of local irritation. The usual course of the malady is somewhat as follows. In a majority of cases like those of ordinary coryza, only that the initial chill and constitutional symptoms are absent. The victim, more frequently during the summer months, suddenly suffers from a feeling in the nose of being "stuffed up," followed by a thin, clear, serous discharge. The mucous membrane of the tear-ducts is swollen, causing lachrymation, itching in the eyes, and the conjunctivæ are infected. Violent paroxysms of sneezing repeat themselves again and again throughout the day. Exposure to direct sunlight or dust produces a paroxysm of sneezing. There is frequently a distressing cough, especially at night.

The amount of constitutional symptoms depends to a certain degree upon the severity of the attack. There is usually more or less irritability of the temper and other manifestations of extreme disturbances of the general nervous system. The patient becomes pale, and there is a general lowering of the physical tone, as shown by lack of vigour, incapacity for mental activity, impairment of the memory, and very low-spirited lassitude, loss of appetite, and marked disturbances of the digestive functions. Attacks become more and more severe with each recurrence, and after a few years the upper respiratory tract is involved. Asthma may develop so like as to be indistinguishable from the ordinary bronchial form. The asthma of hay fever exists by day as well as by night. Both affections may persist alternately all through the summer months.

On Examination of the Nose.

The victims of hay fever form two clinical types.

1. Some pathological condition of the nose and naso-pharynx—*e.g.*, adenoids, hypertrophic rhinitis, diseases of the sinuses, polypi, etc. These structural peculiarities associated with nasal catarrh render the mucous membrane inflamed and irritable, so that the mere touch with a probe may be sufficient to induce an attack.

2. The condition of the nasal mucous membrane. To rhinologists distinguishable as (*a*) The bright red appearance; (*b*) In cases of long standing has a sodden, pale appearance. The membrane is usually extremely sensitive throughout to the use of the probe, but certain areas only produce cough and sneezing. These areas, after a careful examination of a large number of cases, may be said to be confined in 90 per cent. of patients to the structures in the upper and anterior half of the nasal cavity—*e.g.*, middle turbinate and meatus, the region of the ethmoidal cells, and where the septum meets the nasal cartilages.

There may be only one tender spot or several or this hyperæsthetic condition may comprise a large area of the mucous membrane.

Treatment.

The fact that during the last few years so many different modes of treatment have been suggested points out very forcibly that hitherto there has been found no specific. This is not to be wondered at when we take into consideration that there is certainly more than one cause. As a matter of fact we may divide all cases of hay fever into two distinct groups.

1. Those in which there is some pathological cause, for the affection of a gross nature such as polypi, etc.

2. Those in which the interior of the nose appears to be normal, but that the mucous membrane is hypersensitive in certain areas, and when stimulated bring in a typical attack of hay fever.

Those in the first group are usually readily cured by removing the pathological condition and will not come within the scope of the present paper. It is those in Group 2 which give us so much trouble and form a veritable opprobrium of medicine. I wish to point out that these also are really amenable to treatment to a remarkable degree if the subject is approached in a scientific spirit.

It has been suggested for some years that the affection in these cases was of a reflex nature, the morbid impulses starting from some part of the mucous membrane of the nose, and in consequence many attempts have been made to cure this condition by the electro-cautery, chronic acid or some other application to what was supposed to be the offending area. The result has unfortunately usually been failure, mainly from the fact that the wrong spot was taken to be the starting point of the reflex arc. This spot was usually pitched upon from the fact that it was, or appeared to be, more tender than the rest of the mucous membrane. The parts usually cauterised have been the following:—Inferior turbinate, lower half of the septum, or perhaps some tender area over a spur. Careful investigation has convinced me, and the results of treatment have confirmed me in my belief, that hay fever is rarely the result of a morbid condition of those spots, but that the offending area is really confined to the upper and anterior half of the nasal cavity.

Speaking roughly, the essential part of treatment is the *hardening* and *destruction* of this hyperæsthetic area, which may be accomplished either by means of the cautery or by certain liquids of a caustic nature.

The refinements of cautery technique can only be learnt by experience, but there are certain principles which should be understood. Many operators are in the habit of treating the nose repeatedly with the electro-cautery or other escharotics instead of a thorough destruction of the hypertrophic tissues at a single application. This I believe to be bad practice as a rule in hypertrophic cases. It is not desirable to keep the nose continually irritated by repeated applications. In hyperæsthetic conditions where much surface must be treated it is necessary to make several applications, none of which should involve more than the mucous membrane. The application of escharotics is more painful and greater reaction follows.

I will briefly cite a few typical cases in which this treatment was successful.

Case I.—Mrs. S., æt. 27. Suffering for years and during all periods of the year. Violent paroxysms of sneezing on getting up in the morning accompanied with coryza. Well marked acne rosacea. *Examination of Nose.*—Hypertrophic rhinitis and catarrh. *Treatment*—Removal of posterior ends of inferior turbinates with Snare-Cautery and alkaline lotions.

Case II.—Mrs. W.—May be said to be an invalid through hay fever. Dust of any kind or exposure to sun brought on a typical attack. *Examination.*—The nose seemed normal but the mucous membrane presented a bright red appearance and extremely sensitive to the probe, with areas of sneezing. Deviation of septum to right. *Treatment.*—Electric cautery and chromic acid to sensitive areas on five occasions followed with a nasal spray of menthol and ol. eucalyptus in parvoline. I did not operate on the septum. The patient is now able to take every liberty and can expose herself to any of the stimuli that before treatment brought on the disease.

Case III.—Miss H., æt. 23. Hay fever for years. Commenced in July and continued until end of summer. *Examination*—Adenoids with hypertrophic rhinitis. *Treatment*—Removal of adenoids and posterior ends of inferior turbinates, Alkaline lotions used until the cut surface healed and the nose was clear of catarrh.

Case IV.—Mr. M., had been a victim to hay fever and asthma for nearly ten years. *Examination*—Nasal polypi and hypertrophic rhinitis. *Treatment*—Removal of polypi. The hyperæsthetic areas treated with the electro-cautery and trichloracetic acid.

I may state several of my patients have been treated with hay fever antitoxin and powder. In none of them did the remedy act, although some thought it gave them relief at first.

The general hygienic surroundings of the patient, his sanitation, as well as his physical regimen, should be carefully considered and regulated. The marked neurasthenic patients should be treated with tonics—iron, and strychnine.

THE OUT-PATIENTS' ROOM.

METROPOLITAN HOSPITAL.

Two Kinds of Valvular Heart Disease.

By LEONARD WILLIAMS, M.D., M.R.C.P.

THESE two patients illustrate what I have often spoken of here before, namely, that there are two kinds of valvular heart disease. The one kind, with which we are all so familiar, is due to endocarditis, which may, of course, be the result of rheumatic fever, scarlet fever, or other acute specific diseases; the other kind, upon which I have dwelt at considerable length here and elsewhere, is the result of high blood pressure, giving rise to arterio-sclerosis, degenerative aortitis, and, ultimately, to disease of the coronary vessels, narrowing of the aortic ring, and puckering of the valves.

It has been asserted that aortic regurgitation, when complicated with mitral regurgitation, is a very much more favourable disease from the prognostic point of view than aortic regurgitation pure and simple, and it is pointed out in explanation that the reflux through the aortic valves, having to meet the oncoming rush from the left auricle through the mitral valves, puts a strain upon the left ventricle which the latter is frequently unable to endure, unless the mitral valve also is incompetent. It is also said that digitalis, when given in a case which presents regurgitant disease at both valves, is far less dangerous than when given in regurgitant disease of the aortic valves alone, and the reason which is given in explanation of this undoubted fact is that digitalis prolongs the diastole. Now, digitalis undoubtedly does prolong the diastole, but it also has another effect which we are far too liable to lose sight of, namely, that it constricts the peripheral vessels and thereby increases the general blood pressure. To increase the general blood pressure in regurgitant disease of the aortic valves, which has been brought about by hypertension, is obviously to provide an increased burden to the already labouring heart, and I am strongly of opinion that the real explanation of the danger of this drug in this disease is due to the fact that it is so often administered without regard to the original cause of the valvular mischief.

The younger of these two patients, a man, æt. 25, gives us a definite history of rheumatic fever four years ago, and of chorea when he was a child. He has what is commonly called a see-saw murmur at the aortic cartilage, a very much enlarged heart (the *cor bovinum* of the text-books) and a water-hammer pulse.

The other patient is a man, æt. 48, but looks older than he is. He has never had rheumatic fever, or, indeed, any illness of a serious nature, but he has lived well, as it is called. You notice the injected capillaries in his face. On examining his heart you will find that the displacement of the apex beat is comparatively slight. He has dulness at the manubrium sterni, and a definite see-saw murmur at the aortic cartilage. Neither of these patients has any regurgitation at the mitral valve, and neither has any albumen in the urine. If the younger had such regurgitation it would mean that during his attacks of rheumatic fever or chorea, both the mitral and aortic valves had been implicated in the endo-cardial process. He is now very unlikely to develop regurgitation at the mitral valve until his heart dilates through progressive weakness of the myocardium, an event which may not happen for forty years.

The other patient, the older man, is on the contrary very likely at any time to develop a regurgitation at the mitral valve, for his systolic blood pressure is already 165 mm. of mercury, and the myocardium is not likely to be able to stand the strain of such pressure for very long. What happens in these cases is that the ventricle dilates, the mitral ring enlarges, and allows the blood to regurgitate into the left auricle. It is in effect a safety valve process.

Now, if we give digitalis to the younger patient provided that we keep him in bed, and give the drug in small doses, we shall do him no harm. If, however, we are foolish enough to overlook the cause of the aortic regurgitation in the case of the older man, and give him digitalis, we shall probably kill him, whether he is in bed or going about. To give digitalis, therefore, in a case of aortic regurgitation without satisfying yourself fully that the regurgitation has not been caused by, or is not associated with, high blood pressure, is to commit a therapeutic crime. If high blood pressure is present, the only way to treat these cases is to give them drugs such as iodide of potassium, which are calculated to reduce blood pressure, and to see to it that the patients' way of life, especially in the matter of meat foods and alcoholic drinks, is such as to assist the action of the iodides. There are far too many people who give digitalis to any patient who is found to be the subject of a cardiac murmur. That is always unnecessary, and is often very dangerous. As the French say, "Une lésion d'orifice n'est pas une maladie de cœur." Heart disease in this sense can be said to exist only when the myocardium fails and compensation is upset. It is then that digitalis does good, and not until then. To give the drug when the myocardium is acting well is to court disaster by interfering with that compensatory equilibrium which it should be our first care to maintain when present, and restore when absent.

OPERATING THEATRES.

CITY ORTHOPÆDIC HOSPITAL.

EXCISION OF HIP-JOINT FOR PATHOLOGICAL DISLOCATION AND SEPTIC INFECTION.—Mr. JACKSON CLARKE operated on a girl, æt. 6, who had been admitted some weeks previously with a sinus in the outer and upper part of the left thigh and a history of trouble in the corresponding hip-joint of three years' duration. She had been kept under observation in the wards for some weeks, the joint being irrigated through the sinus with 1-40 carbolic lotion, and the evening temperature varying from 1 to 3 above normal. The limb was in a position of adduction with marked shortening, due to displacement of the femoral head above the acetabulum. The child was in a weakened condition, being somewhat emaciated, and her appetite was poor, so Mr. Clarke decided that it was necessary to excise the joint. Operation: A posterior incision was made through the muscles on to the remains of the neck of the bone, which was divided near the inter-trochanteric plane; granulations were removed from the joint cavity by a flushing gouge; the connection of the old sinus with the joint cavity was traced, and the sinus well scraped and flushed; a drainage tube was put in the upper end of the incision and the child returned to bed, a Liston's long splint having been put on the sound side, and an extension of 5 lbs. weight applied to the limb, which had been operated upon, and which was now placed in a position of abduction. Instructions were given for the tube to be removed after twenty-four hours.

AMPUTATION AT THE HIP-JOINT FOR SEPTIC OSTEO-MYELITIS OF THE FEMUR INVOLVING THE HIP-JOINT.—The same surgeon operated on a boy, æt. 6, who had been sent up from the country as a case of hip-joint disease. The patient was in a condition of extreme illness, and was suffering acute pain; his temperature was typically "hectic," and his sleep was broken by spasms of pain which caused him to cry out. No thorough examination could be made until he had been placed under an anæsthetic, and then it was found (1) that there was grating in the hip-joint, and (2) that the lower epiphysis of the femur was separated.

The hip-joint was opened by the posterior incision, and a quantity of pus evacuated. When the cavity had been washed out, the incision was carried along the femur down to below the middle of the thigh, where it was continued down to the bone and the operation rapidly completed by freeing the bone, the muscular attachments being divided close to it. Hæmorrhage was controlled by an assistant grasping the flaps. The operation was then quickly completed in the usual way.

Mr. Clarke said, with regard to case 1, that it illustrated tuberculous disease of the hip-joint, in which conservative measures were inapplicable, and that for two reasons: (1) The presence of a dislocation; and (2) the complication of septic infection by way of the open sinus which had been left after evacuation of an abscess. When the disease is allowed to subside in a case of dislocation, the limb is usually in a very unsatisfactory position, there being considerable *real shortening* as well as a great degree of *virtual shortening* dependent on the adducted position; therefore, if excision was not done, some operation, generally osteotomy, was required in later life, meanwhile the patient was exposed to all the risks of active tuberculous disease, supposing the radical operation were not done. Had the case not been complicated by sepsis, Mr. Clarke said he would have used the anterior incision, but the latter would not have given the necessary facility of drainage. With reference to case 2, Mr. Clarke remarked that the operation was called for as an urgency under circumstances which left no choice, the child having been sent up in such a condition as to make it unsafe to remove him to a general hospital. This case, he thought, thus illustrates the undesirability of separating orthopædic work from general surgery, or, in other words, the chronic cases that constitute the bulk of what is known as orthopædic surgery at times assume acute phases which require wide surgical experience if they are to be adequately dealt with. As further comment on the operation selected in this case, he considered it was the one which gave rise to the least shock, and was most rapidly performed. Another advantage, he pointed out, was that it was, in his experience, less frequently followed by painful neuromata than the higher amputations. On examining the parts removed the interior of the whole of the shaft of the femur was found to be full of pus which extended into the space between the shaft and the epiphysis.

The enterprise of the Liverpool School of Tropical Medicine is exemplified by the issue of a report printed in French on the subject of malaria in the Congo. It is entitled "La Prophylaxie de la Malaria: Rapport de l'Expedition au Congo, 1903–5." In its fifty-eight pages is some exceedingly useful information dealing with the disease, and towards the stamping out of which the efforts of the School of Tropical Medicine are directed. The Government of the Congo Free State will, no doubt, find this volume, which is neatly bound, of immense utility.

At the last monthly meeting of the Belfast Rural District Council a letter was read from the Local Government Board drawing the attention of the council to the exceptionally high death-rate in the country from pulmonary tuberculosis (consumption), and expressing the hope that in the interests of public health the Council would take such measures as were calculated to diminish the present high mortality from consumption in so far as their district was concerned.

TRANSACTIONS OF SOCIETIES.

THERAPEUTICAL SOCIETY.

Meeting Held July 14.

A general meeting of the Therapeutical Society was held on Saturday, July 14, in the Pharmacological Laboratory, Cambridge, at the invitation of W. E. Dixon, Esq., M.D., Assistant Professor of Pharmacology.

Sir Lauder Brunton, the President, was in the chair, and thirty-five Fellows and visitors attended the meeting.

Dr. W. E. Dixon showed the action of various drugs on the blood supply to the lungs of a pithed cat, demonstrating that adrenalin and ergot increased the amount of blood in the lungs. Squill produced slight congestion only, while Strophanthus somewhat diminished the amount of blood in the lungs.

Dr. G. S. Haynes demonstrated the action of Squill on the mammalian heart kept at a constant temperature, and perfused with normal saline solution for half an hour, and then with 1 in 2,500 solution of B.P. tinct. scillæ. This had an extraordinary powerful effect, increasing the force of the heart-beat at least tenfold in about one hour. Death occurred in systole in two hours.

Dr. G. S. Ricketts showed specimens and tracings proving that atheroma could be produced in rabbits by any substance which markedly augmented the blood pressure on injection into the circulation. This occurred especially with adrenalin, nicotin, tobacco, and squill. The rabbits were injected daily and killed after treatment for three weeks or three months. He also shewed microscopical specimens demonstrating the rupture of elastic fibres, and the deposition of calcium salts.

Dr. T. G. Slade demonstrated the action of muscle extract on plain and striped muscle proving that the extract after fatigue was more powerful than that obtained after rest. He also showed photographs of the ergograph, and the interesting results obtained by its means.

Dr. B. Hudson showed the action of physostigmine on the frog's heart, which was complicated as it acts on nerve cells, nerve endings, and muscles, and some interesting tracings throwing light on the vexed question of the action of nerve endings.

Dr. Horsey, of Toronto, showed aortæ of four foxhounds with atheromatous changes, also an apparatus for perfusing surviving organs.

After a tea, supplied by Dr. Dixon, the visitors went to the Botanical Gardens, and were shown round by the Curator R. Irwin Lynch, Esq., M.A., who exhibited many curious and medicinal plants, and explained their uses, and also an interesting collection of bog plants. Thirty-five of the Fellows and visitors then dined together in Downing College Hall, afterwards many returned to London, but eight remained in Downing College till Monday.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

GERMANY.

Berlin, July 28th, 1906.

The last number of the *Zeitschrift f. Beam.* has a paper on

Spontaneous Penetrating Rupture of the Heart.

by Dr. Kypke-Benchardi. Spontaneous ruptures of the heart are much less frequent than the traumatic. The case described was that of a man, æt. 58, who one day got up feeling unwell; at midday he had a light meal, after which he died suddenly. As both the brother and the wife of the individual charged each other with having poisoned him, a judicial *post mortem*

examination was made. This revealed no symptom of poisoning, but two lacerations in the left cavity, the larger being 7 cm. in length. This for a short distance had penetrated through the wall. The pericardium, which was uninjured, was filled with blood; the heart was strongly hypertrophied, and showed fatty degeneration of the muscular structures. The case fitted in well with others of its class, in which the muscles are so much changed, but little is required to bring about the rupture. It will be observed that the *post mortem* completely set aside any possibility of poisoning.

CHANGES IN THE SKIN IN PSEUDO-LEUKÆMIA.

A paper on this subject appears in the *Arch. f. Dermat. end Syph.*, 80-1, by Dr. P. Linser. A man, æt. 54, had a considerable number of tumours varying in size, about the face, neck and body. They sprang from the skin, but a part of them formed tumours reaching into the underlying muscular structures. The whole left lower arm and hand and part of the upper arm were thickened with elephantiasis. A portion of this excised and examined microscopically showed a round-celled infiltration penetrating into the muscular tissues without any orderly arrangement. The diagnosis was difficult; mycosis fungoides and multiple sarcoma were thought of. Examination of the blood gave the first correct indication; this showed a comparatively excessive increase of the leucocytes from 25 to 45-67 per cent. This, along with enlarged spleen and liver and inguinal and axillary glands, left no doubt that the case was one of pseudo-leukæmia with cutaneous tumours. As the patient, without any known cause, got an attack of pneumonia of the lower lobe of the right lung, the tumours and infiltration became markedly better, but after the cessation of the fever they quickly returned to their old condition. Death took place about two months after leaving hospital, the patient previously suffering from shortness of breath, perspiration, splitting headaches, and severe epistaxis. A few days before death the tumours suddenly disappeared. In a second case, that of a man, æt. 58, who had the same symptoms of pseudo-leukæmia (increase of leucocytes to 94 per cent.) enlargement of the liver, spleen and the superficial glands, the skin affection that accompanied the disease was an erythrodermia exfoliativa, the anatomical substratum of which was a lymphocyte infiltration of the skin through its whole thickness with œdema. The skin was thickened over the whole body, reddened and covered with scales. In this patient also an intercurrent attack of pneumonia took place, and another time an attack of bronchitis came on with high fever, and some weeks before death a regression of the skin infiltration took place. During the latter part of his life such an increase in the absolute number of leucocytes took place that one could say there was a transition from pseudo-leukæmia into true lymphatic leukæmia.

From his observations, the author adheres to the view of Pinkus, that the changes in the skin are not due to leucocytes coming from the blood, but that they are developed locally out of the traces of lymphatic tissue that are normally present in the skin.

A RECORD TEMPERATURE.

Dr. R. Heller reports a case of exceedingly high temperature in the *Munch. Med. Wochensch*, 23, 1906, the cause of which was unexplained. He speaks of it as the highest yet measured.

In a girls' institute the writer was called upon to treat several of the inmates for influenza. A girl, æt. 15, complained of general malaise, and showed a temperature of 37·3° C. In the afternoon the writer was sent for again, as the temperature had risen to 44° C. (about 112° F.); it was taken with four exactly-tested thermometers one after the other. Whether the temperature rose over 113 could not be known, as the instruments did not register above that figure. The pulse never reached beyond 120. The general condition was fairly good. Objectively, there were a commencing splenic tumour and a systolic cardiac murmur at the apex. After a few days the temperature became normal, and recovery took place.

THE SERUM TREATMENT OF SYPHILIS.

The *Archiv. f. Dermat. end Syph.*, 79, 1. contains a paper by Professors Risso and Cippolina, on the results obtained by treating syphilis, especially in its secondary and tertiary stage, with serum obtained from dogs, asses and goats. The animals were previously treated by the injection of blood from persons in the secondary stage of the disease, being injected subcutaneously and into the peritoneal cavity. With the serum, to which a small quantity of a solution of the blood corpuscles was added, thirty-four syphilitic patients were treated by injection into the muscles. The results obtained were good. Especially in the cachectic condition in the later stages of syphilis the results were excellent. Dog serum appears to be the most active, but it could not be borne long in the doses first given, but by lowering the dose, or by giving it every second day instead of every day, the disagreeable accompaniments were avoided. These were local pain, urticaria, swelling of the regionary glands, &c. The dose was 1 to 2 ccm.

AUSTRIA.

Vienna, July 28th, 1906.

RAYNAUD'S DISEASE.

AT the Gesellschaft Necker exhibited a boy, æt. 12, suffering from the disease known by the name of the clinicien who first differentiated it in 1862. It was found at a later date to consist of three stages (*a*) local asphyxia, (*b*) local syncope, and (*c*) gangrene. Whether the disease is vascular or neurotic is not easily affirmed at the present time.

The boy was pale, cold, and weakly looking. The skin was livid, thin, and corrugated, the hand having ridges with punctiform hæmorrhages. The right foot was minus the terminal phalanges of the second, third, and fifth toes. The stumps resembled an amputation with the exception of a small nail on the terminus. The same conditions existed on the second and fourth toes of the left foot. On the extensor side of the second toe and the flexor side of the fifth toe were two large granulating ulcers. On the upper part of each foot were linear scars of operations.

On the ulnar side of the right-hand was a diffuse swelling extending over the metacarpal bones, where the trochlea of the fifth metatarsal was easily felt.

On the left hand all this was absent except the scar in which was a fistula communicating with the bone from which a thin ichorous fluid oozed. The first second, and third fingers of the left hand, still intact, were thick and bent with irregular surfaces and of a light brown colour. The left knee was swollen and had a ball shape fixed in flexion. On the scalp, areas about the size of a shilling, were denuded of hair and some of them covered with favus-scutalis. The skin on the free margins of the ears was excoriated and irregular.

According to the father's story, all these changes took place gradually during the last eight years. From birth till the child was four years of age it was in perfect health and of normal appearance. Shortly after this period the hands became blue and swollen, which was soon followed by the foot and ears. As this occurred during the winter little heed was taken of it at the time, but whether the child was exposed to severe cold, as to cause frost bite, cannot be exactly determined. We learn that after this winter the ulcers on the toes commenced, and the small bones fell out of the toes, later the fingers.

Every year since this ulceration went on; in winter the parts were of a reddish blue, followed by necrosis and improvement in the warm summer season, when the bones fell out of the parts. It was three years after the invasion, or five years ago, that the dorsum of the foot began to swell; a little later the right hand, which induced the parents to leave him in hospital where they were cut open without the beneficial result expected. The swelling of the knees commenced only six months ago, after a supposed slight injury. It may be well to state that four years ago the patient was seized with a severe itching all over the body, with red blotches on he skin and favus in the hairy parts.

Examination of the nerve system was normal with the exception of a slight hyperstæhesia. Necker came to the conclusion that this was one of Raynaud's disease complicated with bone affection and articular tuberculosis.

The livid, gangrenous nature of the disease certainly points to a vascular defect, but the angiospasms, itch and vesicles point to a neurotic centre, which may be located in the vaso-motor centre of the medulla and all the phenomena induced by an irritation of that ganglia. Syphilis and hysteria have many points in common, and must always be eliminated before our diagnosis is complete, as both produce the colour and gangrene.

Tetany.

Konigstein next gave a report of his investigation of the thyroid for the morbid source of tetany. He had a typical case of spontaneous or idiopathic tetany from whom he obtained the epithelial bodies of the gland, but found the iodine colouration failed entirely when compared with the control experiment. He therefore doubts if this be the correct centre of morbidity.

Rontgen Rays and Carcinoma.

This controversial subject has yet another exponent in Freund, who acted on a woman, æt. 60. with the rays for carcinoma of the mamma. The neoplasm was three years old, in the form of a knobby swelling, about the size of a man's fist, and began to ulcerate a year ago. The skin and pectoral fascia were firmly bound up with it, and the glands of the axilla large and swollen, while the patient was in an exhausted cachectic condition. From December 27, 1905, till February 19th—about three months—twenty exposures for six minutes with a "hard" Rontgen tube were applied. The purulent discharge was converted into a serous fluid, and by the end of April disappeared altogether. Now there is nothing to be seen but a smooth cicatrix on the thoracic wall; the glandular swellings in the axilla have gone, and no appearance of metastatic nodules can be found anywhere.

Nothing now remains but the telangiecstasis common after Ray treatment.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Graduation Ceremonial at Edinburgh University.—The summer graduation ceremony took place in the McEwan Hall on July 27th, when the degree of L.L.D. was conferred on Sir Donald Currie, Emeritus Professor Sir A. R. Simpson, Senor Antonio da Veiga Beirao, an eminent Portuguese jurist, and Baron Descamps, Professor of International law at Louvain. In presenting Professor Simpson for the degree, Sir Ludovic Grant paid a graceful tribute to his long service in the University, to his eminence in gynæcology, and to his prestige as a teacher. The occasion of the fiftieth anniversary of his graduation as a Doctor of Medicine was a most fitting time for the University to recognise the lustre he has shed on his *alma mater*. After the ordinary degrees had been given, the new graduates were addressed by Professor Annandale, who successfully avoided the usual rather hackneyed platitudes of orations of this nature, in choosing as his topic "Quackery, otherwise Humbug."

General Medical Council.—A circular has been issued by Drs. G. A. Gilson and F. W. N. Haultain, inviting the adhesion of those who are in favour of Dr. Norman Walker's candidature for the post of Direct Representative for Scotland on the General Medical Council. Although he now practises as a specialist, Dr. Walker was for a number of years in general practice in the country and hence has the knowledge borne of personal experience of the point of view of a general practitioner. Added to this is his intimate acquaintance with the educational aspects of medicine, his long experience in medical affairs through his connection with the British Medical Association, and his unrivalled business capacity—all of which seem to mark him as eminently adapted for a seat on the General Medical Council. His election would undoubtedly strengthen that body, and his very numerous friends throughout Scotland are sanguine of his success.

LETTERS TO THE EDITOR.

INSPECTION OF FOOD BILL.

To the Editor of The Medical Press and Circular.

Sir,—With regard to the Inspection of Food, Bill that has been recently introduced by the President of the Local Government Board, it seems clear enough that if it pass it will enable the Board to provide for the efficient examination of food entering the Metropolitan county. This project of law has gained the approval of the County Council Committee, which has had the question in hand. They report to the Council that Mr. Burns' Bill will, if it become law, give to London all that the Council could have expected from any Bill promoted by themselves. They, however, express the opinion that the Bill will not fulfil its purpose in London unless the Council, as the only authority having jurisdiction over the whole of the county, is made the authority in London for the administration of any regulations which may be made under the Bill. To my mind, that view expresses a condition absolutely necessary to the ultimate success of the Bill in attaining its avowed object. But surely we must have also a higher supreme authority for final administration, if necessary.

I am, Sir, yours truly,

Croydon, July 26th, 1906. Food Reformer.

THE SCOTTISH DIRECT REPRESENTATIVE ELECTION.

To the Editor of The Medical Press and Circular.

Sir,—We have been instrumental in promoting a requisition to Dr. Norman Walker inviting him to be a candidate for the post of Direct Representative for Scotland on the General Medical Council. Dr. Walker received so large a measure of support on the last occasion and has since continued to take so active and useful a part in the promotion of the improvement of medical education as well as in other matters of medical politics that we have every reason to believe that on this occasion his candidature will be successful.

The requisition has been largely signed by practitioners from all parts of Scotland, and Dr. Walker has indicated his willingness to accept it.

We shall be glad to hear from those who wish to join the General Committee.

We are, Sir, yours truly,

G. A. Gibson, 3, Drumsheugh Gardens, Edin.
F. W. N. Haultain, 12, Charlotte Square, Edin.

MOTOR CARS AND DUST.

To the Editor of The Medical Press and Circular.

Sir,—Will you allow me to remark that your note on "Motors and Influenza," on July 25th, 1906, is conceived in a deplorably anti-progressive spirit? Have you not momentarily forgotten the *role* you perform in creating that health conscience which Dr. Clouston wishes the nation to possess? The motor does not produce dust—how can india rubber grind stone into dust—it is the horse, pounding with his iron hoof, and the metal wheel of the vehicle he draws that are responsible for the condition you justly condemn. Rather enlighten your readers on the subject of the diseases traceable to the presence of the horse on the road.

I am, Sir, yours truly,

A. W. Gilchrist, M.D.

Nice, July 28th, 1906.

[Road dust is made both by attrition of macadam and by crushing up of dry mud. The soft motor wheel certainly will crush the dried mud, and it seems to us that the solid iron shod tyre beneath a heavy vehicle must grind up stones and pebbles galore. In any case

Dr. Gilchrist may be reminded that the motor is an energetic distributor of dust, which fits our argument even if his contention were right that it is not a creator of that nuisance.—ED. M.P.&C.]

MEDICAL REPORTS ON POLICE CASES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The remarks in the last two issues of your valuable journal with regard to Medical reports as Police witnesses are very apt. The amount of work that a house surgeon has to do in an ordinary hospital or infirmary is quite sufficient without his being constantly applied to by this, that, and the other person for information about different patients. It ought to be no part of his regular duty to give news of patients, except in the form of a regular official report when such is needed for police or other purposes. Everybody interested in a patient thinks he has a perfect right to get hold of the house surgeon during any hour of the day or night that he is passing the hospital, to make inquiries. There ought to be a proper system for reporting patients' progress at every institution. I am constantly pointing this out to the Committee of my hospital, and I am very glad to have your remarks to support me in my contention. Please "peg away" at it. I am, Sir, yours truly,

July 26th, 1906. UNIT.

INJUDICIOUS FEEDING.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

DEAR SIR,—Over-indulgence in either food or drink is sure to bring its own punishment later on. This may appear a "truism," but if so, is little regarded by the majority of people, who never lose an opportunity of feeding, as can be seen at almost any hour of the day by looking in at any catering establishment. There are numbers of people who imagine the more and the oftener they eat and drink the stronger they will be. The very converse is more likely the truth. In times gone by the custom existed, when introduced to another, that it was common politeness to ask him to have a drink. Nowadays, "Come and dine." I am fully assured *all should eat in proportion to the amount of mental or bodily work done*, or about to be done. Would an owner of horses, who had no work for them to do, feed them as highly as if they had a heavy day's work before them? I should imagine that the injury done by over-fasting (as in the case of professionals, who do so for gain) the lesser evil than gluttony or drunkenness. The balance between the secretory and excretory organs must be maintained if we wish to prolong our days—a suitable diet chosen and the proper quantity ingested at suitable intervals, and, as I said previously above all, in proportion to the amount of the mental or bodily work done.

Yours truly,

July 27th, 1906. ALEXANDER DUKE.

SPECIAL ARTICLES.

THE CENTRAL MIDWIVES BOARD.

AT the last meeting (Thursday, July 26th), Dr. CHAMPNEYS in the chair, the secretary read a letter from the Clerk of the Privy Council with regard to the new rules and Poor-law institutions as "approved by the Board," the Council deeming it necessary to act by the advice of the Local Government Board, who consider some such provision of midwives from their institutions needful.

"SIR,—Referring to your letter of May 9th last, I am directed by the lords of the Council to state that their lordships have given their careful consideration to the revised rules made by the Central Midwives Board and to request that you will lay before the Board the following amendments that are deemed necessary therein.

"Their lordships' attention has been called to a resolution passed by the Central Midwives Board on February 16th, 1905, 'that no Poor-law institution be approved as a training school for midwives unless the average number of deliveries reaches 75 per annum'; and also to a discussion which took place at a recent meeting of the Central Midwives Board on a memorandum which suggested that 'in future as a rule, a number of not less than sixty cases of labour annually be essential for an application to be approved from a doctor desiring to teach pupils in an infirmary or workhouse which is too small to be a recognised school'; and I am to point out that, in their lordships' opinion, resolutions which have the effect of 'regulating the course of training' come within the purview of Section 3.1.(c) of the Act, and consequently should be embodied in rules to be submitted to the Privy Council for approval.

"Their lordships are moreover advised that it would be desirable in the interests of public health, and in connection with the problem of infant mortality, that a rule should be added to Section E, making it the duty of midwives—where the supervising authority requires it—to notify within forty-eight hours to such authority every birth occurring in their practice together with the name and address of the parent.

"I am to add that with a view to ensuring sufficient consideration of the amendments to the draft rules, their lordships propose to extend the existing rules for another six months from the date of their expiry on August 12th next."

The PRESIDENT said that it was a practical detraction of the Poor-law Institutions from their hands, as they would have nothing to do with their training or examinations.

Dr. PARKER YOUNG rose to protest against the decision of the Privy Council. He was extremely sorry and surprised, and considered it retrogressive to allow the L.G.B. to supersede the C.M.B., and so make two authorities. After a delay of over two months, the rules, which it had been hoped would have been amended, were now extended over six months, and he proposed a discussion by a special committee. This was agreed to.

THE PAYMENT OF MEDICAL FEES.

In connection with a letter (read) from Mr. Ward Cousins, saying he had supported a resolution to the Privy Council in favour of amending the Act with regard to the payment of medical men called in by midwives, a letter was read from a midwife asking if any decision had been arrived at, as lately she had a case where one doctor summoned had to call in another in consultation, and the circumstances of the patient did not guarantee any fee, nor had the doctors had any.

Dr. PARKER YOUNG remarked that under the circumstances the Poor-law doctor ought to have been summoned, as the guardians had the power of making the family pay if they could or had themselves to give the fee.

The PRESIDENT added that this question of fees came up over and over again. At present, wtih regard to liability, clearly the doctor or midwife who had undertaken to deliver the woman was liable. If a midwife, then she is responsible, and the doctor called in is merely a consultant, and the nurse is responsible for obtaining his fee. People of the poorer classes were likely to, and did, seek unqualified women, fearing a L.O.S. would send for a doctor.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

AT an ordinary meeting of the Council, held last Thursday at the Royal College of Surgeons, Mr. Henry Morris, president, in the chair, it was decided, on the recommendation of the Board of Examiners in Dental Surgery that the period of instruction in mechanical dentistry be reduced from three to two years. The Board also expressed the opinion that it is desirable to admit a student to the first professional examination as soon as he can produce the required certificates, without necessarily completing six months' attendance at a dental school and hospital, and the council decided to alter the regulations so as to meet this

recommendation. The announcement of an interesting gift to the museum of the college was reported to the council in connection with a tree, under the shade of which both St. Luke and St. Paul, according to Dean Farrar, probably rested. The tree, which still stands in the island of Cos, in the Ægean Sea, is surrounded by a podium or raised platform, doubtless built to support the trunk of the tree after it had become hollow and weak from age. The lower branches are still well preserved, and have been shored up by pieces of antique columns, over the upper ends of which the branches have grown like caps in consequence of the pressure of their own weight. Close by the tree is a solid marble seat, which is said to be the chair of Hippocrates, the father of medicine, and it is supposed that he taught the art of healing from that seat. He was born in Cos 460 B.C. This gives a clue to the age of the celebrated plane tree, which must be considerably more than 2,000 years old. Dr. Edward Clapton, formerly physician of St. Thomas's Hospital, whose devotion to archæology is well known, sent an agent to procure some fragments of the tree. This was done, but at considerable risk, as the Sultan, who attaches great importance to its preservation, has given strict orders that no one is to touch the tree, which is, therefore, guarded day and night. The specimens which Dr. Clapton obtained have now been generously handed over to the Royal College of Surgeons, where they will be displayed in the museum. They consist of two pieces of branch, a bundle of twigs from the branches, and a small box of leaves and round button-like catkins of the plane tree. Mr. John Tweedy and Mr. Edmund Owen were elected, and Mr. Henry T. Butlin was re-elected, members of the Executive Committee of the Imperial Cancer Research Fund in the vacancies occasioned by Mr. Morris having, as president of the college, become an *ex officio* member of the committee, and by Mr. Langton having ceased to be a member of the council of the college. It was decided to send an address of congratulation to the University of Aberdeen on the occasion of the celebration of its Quartercentenary next September.

THE LOCAL GOVERNMENT BOARD FOR IRELAND AND TUBERCULOSIS.

The Local Government Board for Ireland is showing a commendable, even if somewhat tardy, interest in the struggle against tuberculosis. On at least two previous occasions it circularised the local bodies under its superintendence, and in a further circular dated June 28th, 1906, it again directed attention to the importance of the subject. Having enumerated some of the figures relating to the consumptive and tubercular death-rates, and contrasted them with the corresponding figures for England, the Board proceeds to give practical advice.

In the first instance the Board recommends the thorough instruction of those in charge of consumptive patients in all that is necessary to enable them to prevent the spread of the disease. It is advised to distribute leaflets and pamphlets bearing on the subject, and to exhibit posters in prominent and suitable places. A specimen of a pamphlet well adapted for its purpose, and a specimen poster have aleso been sent round by the Board.

Next, attention is drawn to the prevalence of general insanitary conditions, and particularly to the imperfect housing of the poorer classes.

Finally, the question of providing sanatoria is discussed. The Local Government Board points out that it is in the power of local authorities, either individually or collectively, to provide hospitals for the inhabitants of the districts, or in the alternative, to enter into an agreement with any existing hospital for the reception of sick inhabitants. The latter plan is suggested as a temporary expedient, while the former is advised as a more permanent scheme. The Board also suggests that sputum should in doubtful cases be submitted to a skilled bacteriologist.

There is no doubt that the suggestions we have just enumerated are of excellent intention, and if followed, would doubtless result in some improvement in the health of the community. We fear, however, that before any radical improvement can be effected, there must be a thorough and complete revolution in the sanitary system of the country. At present, Ireland, outside the great cities, is without sanitary control of any but the most haphazard description. The salary of the medical officer of health for an urban or rural district varies from £5 to £15 or £20 per annum. Is it possible to expect serious sanitary work under such conditions? It is within the power of the Local Government Board to refuse to sanction the appointment of a medical officer of health at any but a reasonable remuneration, but we do not remember hearing of this power being exercised. It is absurd to expect local boards to lead until the Local Government Board show the way, and we would commend to the latter the advice given by them to local bodies:—

"It is scarcely necessary to remind the Council that any efforts on their part of a half-hearted or intermittent character are not likely to be attended with satisfactory results, and that success can only be achieved by vigorous and sustained action"

The activity of the Local Government Board up to the present has shown itself by these circular letters, scattered over an interval of five years.

Let us add that all who take an interest in the struggle against tuberculosis will find much valuable material in Dr. McWeeney's Report to the Local Government Board on the International Congress on Tuberculosis held last year at Paris.

OBITUARY.

WILLIAM NOBLE SMITH, F.R.C.S.Ed.

We regret to note the death of the well-known orthopædic surgeon, Wm. Noble Smith, on June 20th, at his residence, Queen Anne Street, London. Educated medically at St. Mary's Hospital, he took the Diploma of M.R.C.S.Eng. and L.R.C.P.Lond. in 1868, and the Fellowship of the Royal College of Surgeons of Edinburgh, in 1880. He acted as house surgeon at St. Mary's and the Lock Hospital in London and at the Bristol Children's Hospital. For many years he was connected with the City Orthopædic Hospital, and at the time of his death was Senior Surgeon. He was recently elected on the Council of the Scotch Diplomates Tercentenary, and acted as one of the official delegates of that body at the recent Quartercentenary of the Royal College of Surgeons of Edinburgh. He made many contributions to the literature of orthopædic surgery. In private life he was of a most kindly, genial, and cultured disposition, and his loss will be deeply felt by a wide circle of acquaintances.

RICHARD THOMAS PARKINSON, M.D. BRUX.

We regret to record the death of Dr. Richard Thomas Parkinson, of Manchester, suddenly on the 21st ult., while visiting a patient. Death is believed to have been due to heart failure. Dr. Parkinson, who was in his 61st year, held the M.D. degree of Brussels. He was also M.R.C.P. of Edinburgh and L.R.C.P. of England. He qualified in 1873, after pursuing his studies at the Owens College.

J. H. BREACH, M.R.C.S., L.S.A.

The death of Dr. J. H. Breach, of Yattendon, took place on Wednesday, July 18, after an illness of five months' duration. For several generations the medical practice which he carried on had passed from father to son. James Henry Breach was born in 1855, and trained at King's College. He returned to Yattendon and worked with his father, succeeding to the practice in 1882. The funeral was attended by practically all the whole of the inhabitants of Yattendon, and by a large number from adjoining parishes.

R. F. COOK, M.B., M.R.C.S., L.S.A.

ONE of the oldest medical practitioners in Gateshead has been removed by the death of Dr. Robert Foreman Cook at Harrogate, on July 23. He qualified in 1863, and two years later was appointed medical officer to the Gateshead Workhouse. He held this position for thirty-two years, and for a long period was also public vaccinator in the parish. In addition to this he carried on a large general practice in the town. In October, 1897, he resigned his public appointments and retired from practice. Four or five years ago he removed to Harrogate. From 1874 to 1900 he was an officer in the 5th Volunteer Battalion Durham Light Infantry, and on his retirement held the rank of surgeon-lieutenant-colonel, with the V.D. decoration. Of a genial and kindly disposition, he was well known for his generosity to poor people requiring help, and the organised charities of the district also found in him a willing helper and active friend. The deceased gentleman leaves a widow and one son.

REVIEWS OF BOOKS.

PAVY ON CARBOHYDRATE METABOLISM (*a*).

To the physiologist who has been brought up since his earliest scientific days in the firm belief that one of the most important duties of the liver is to store the carbohydrate of the food in the form of glycogen, and to dole it out again in the form of dexture to the various tissues and organs of the body according as they indicate their need for it, the present little book, embodying most of the well-known views of Dr. Pavy, must appear somewhat heretical. But even while adhering to thisview we must in fairness admit that the views here expounded are very plausible, and are expounded and defended with wonderful clearness and exactitude. Briefly stated Dr. Pavy's theory is as follows :—(1) Dexture as such only exists in minute traces in the blood at any time in the normal individual, and it is present in the normal urine in proportion to its presence in the blood, the kidney cells not being possessed of the power of preventing its passage through them ; (2) the malton and dexture formed in the alimentary canal are built up as they traverse the intestinal epithelium into complex molecules, and are distributed to the body as constituent portions of the circulating proteid and fat. In support of this statement he points out that the proteid molecule can always be demonstrated to contain carbohydrate chains, and that fat can undoubtedly be built up out of carbohydrate. (3) The lymphocytes found in the intestinal villi probably play an important part in the building up processes. They themselves proliferate enormously during digestion, and passing into the circulation *via* the thoracic duct are accountable for the digestion lymphocytosis that normally takes place. (4) The glycogenic function of the liver is purely a reserve force, designed to temporarily stop any glucose that may have escaped "assimilation" in the villi, and all glycogen, which is retained in the liver is subsequently built up into fats or is incorporated with proteid molecules. (5) The essential primary defect in diabetes is a failure of "assimilative power" in the intestinal villi, and it is best met by a complete withdrawal of all carbohydrate from the food. In support of the above statements numerous experiments are quoted and many facts adduced, many of them quite incontestable, but yet we think that the following criticisms may be put forward, and must be answered before the conclusions can be accepted :—(1) Dr. Pavy does not seem to us to explain why it is that blood contains any glucose in the free state at all, though he apparently admits that some is invariably present. According to his view any dexture that escapes the villi should be assimilated in the liver into proteid or fat molecules. Whence then comes the free glucose of the blood, for he does not definitely accept Locivi's idea ' that the sugar which is ordinarily looked upon as being in a free form in the blood is in reality in a loosely combined state " ? (2) Should not the urine contain,normally,glucose in a state of higher concentration than it is to be found in the blood, if the kidney is incapable of stopping the glucose molecule ? Urea, uric acid and other constituents are in a much higher state of concentration than in the blood, and in diabetes the sugar also may exist in higher percentage in urine than in blood. In short, if one substance appears in higher concentration, should not others also ? and yet there is difficulty in proving that urine normally contains carbohydrate at all ! This seems to us to be opposed to the view that the renal cells cannot stop the passage of glucose, provided that glucose is admitted to exist at all in the free state in the blood. (3) No reference is made to the usually accepted statement that the blood in the hepatic vein contains more sugar than that in the portal vein in the intervals between digestion. (4) The fact that portal blood admittedly contains much glucose during the digestion of carbohydrate food is passed over too easily. If the liver function is only a reserve one, why should it be called upon after every carbohydrate meal ? (5) The statement that the fat in the lacteals of rabbits after a meal of oats must be derived from the carbohydrates of the oats, cannot be accepted until definite quantitative analyses prove that the lacteal fat is in excess of the ingested fat. The mere affirmation that it is in excess is not enough and Pavy's remark that " only from time to time are such instances as I have depicted come across " (p. 89) seems to us to be against rather than in favour of his theory.

We are much more inclined to agree with his views on the treatment of diabetes, and regard with much satisfaction his remarks on the so-called " potato treatment," while, from one of his experience, the hint regarding a return to carbohydrate food when the weight begins to fall, although the urine remains sugar free, must be regarded as most valuable (p. 104). On the other hand, his statements regarding acidosis and the stoppage of all carbohydrate food must at present, we think, be received with caution.

While offering the above brief criticisms, we must state that we have read the book with genuine pleasure, and must congratulate the author on his method of maintaining the theory with which his name has been so long associated. We recommend the work to every student of physiology and can assure him that it will afford much food for thought.

(*a*) " On Carbohydrate Metabolism." A Course of Advanced Lectures on Physiology, delivered at the University of London, May, 1905. By F. W. Pavy, M.D., F.R.S., Consulting Physician to Guy's Hospital. London : J. and A. Churchill, 1906.

THE FOOD FACTOR IN DISEASE. (*a*)

THIS is a monument of orderly research, painstaking effort, and logical arrangement. There is much that is reminiscent of a bygone pathology, but more that is quickened by modern conceptions. The work is philosophic rather than experimental. It is the product of a methodical thinker and a judicious compiler rather than the record of an original investigator. But by passing the disconnected and unexplained observations of others through the fine sieve of his own disciminating judgment, the author has succeeded in producing a work which is highly original in many of its conclusions, suggestive and stimulating in an exceptional degree, and marked throughout by a literary style, graceful and luminous, and such as is unfortunately but seldom met with in medical works. Dr. Hare states that his work is an investigation into the humoral causation, meaning, mechanism, and rational treatment, preventive and curative, of the paroxysmal neuroses (migraine, asthma, angina pectoris epilepsy, etc.), bilious attacks, gout, catarrhal and

(*a*) " The Food Factor in Disease." By Francis Hare, M.D., late Consulting Physician to the Brisbane General Hospital and Inspector General of Hospitals for Queensland. In two volumes. Vol. I. pp. xlv., 497. Vol. II., pp. viii., 535. London : Longmans, Green and Co., 1905. Price 30s. net.

other affections, high blood pressure, circulatory, renal, and other degenerations. The work is mainly deductive and not inductive. The argument is well presented and is ingenious and the facts supporting it are many, varied and substantial. Dr. Hare believes that the nitrogenous and carbonaceous materials of food differ essentially in their function and are in many respects diametrically opposed. He deals with the income and regulation of carbon to the blood, the physiological methods of decarbonisation. He seeks to show that in certain circumstances the carbon expenditure of the blood falls below its income, and that there occurs an accumulation of carbonaceous material which may be considered pathological. To this morbid blood state the term "hyperpyræmia" is applied. The greater part of these two bulky volumes is devoted to evidence which the author considers demonstrates the widely prevalent influence of this morbid condition as etiologically connected with many abnormal states, the nature of which hitherto have remained obscure. He studies in much detail the connection of hyperpyræmia with migraine, asthma, angina, epilepsy and other paroxysmal derangements, gout, uricæmia, and certain catarrhal pyrexial and hæmorrhagic conditions. It is impossible in the space at our disposal to discuss or dispute Dr. Hare's thesis, but while every page offers suggestive contentions and well-selected facts in substantiation, there is much that will not be allowed to pass unchallenged both by pathologists and cliniciens. There is much, however, in these pages of practical service. Perhaps the most generalised conclusion which will be arrived at from a consideration of the author's theory of hyperpyræmia is the need to pay greater attention to the "stoking" of the human engine. An interesting feature of the work is the well selected and excellently described series of clinical cases. Dr. Hare's volumes with their twenty-six chapters and nine hundred and fifty-eight duly numbered sections, with their careful headings, and with summary at the head of each chapter and conclusion at its end, offer us a model of orderly presentation which we would gladly see followed in some other works. Most of the work, we are given to understand, "was written in a country destitute of reference libraries," and this makes Dr. Hare's achievement even still more notable and praiseworthy, for the work teems with references, and evidently the greatest care has been taken to ensure their accuracy. The author has presented his argument with much modesty, conspicuous precision, and through all there is a scientific spirit and a literary presentation which is exceptionally fascinating; and we commend the study of these volumes to all interested in speculative medicine.

SKIN DISEASES AND INTERNAL DISORDERS. (*a*)

The four lectures contained in this volume were delivered at the New York Skin and Cancer Hospital last year and are now published by special request. The aim of the author is to impress on dermatologists the necessity of taking a broader view of the diseases of the skin than is often done by considering the relations of the skin to internal disorders. As a result of the present day specialism there is, no doubt, a tendency among dermatologists to consider the skin as an independent structure with diseases of its own, and this tendency has perhaps led to the expenditure of an undue amount of labour in the naming and classifying of these diseases. This insistence on the importance of classification may lead the student for the moment to neglect the more general principles, but it would seem to us that this neglect must be very quickly corrected by the exigencies of practice. Every physician who is worthy of the name must recognise that it is the patient, and not merely the disease as an isolated phenomenon of the patient, that he has to treat. Dr. Bulkley has pointed out many instances in which skin lesions evidently depended on general constitutional affections; but they remain merely instances, and we look in vain in his lecture for any general principles which might guide us either in diagnosis or treatment. The truth seems to be that as yet dermatology has not sufficiently advanced to enable us to formulate any such principles, except in very few instances, and for the present we must be content merely to apply to the treatment of skin diseases the obvious rules of general therapeutics. The book before us impresses this fact strongly on the reader, and consequently will be of value to many practitioners.

(*a*) "On the Relations of Diseases of the Skin to Internal Disorders with Observations on Diet, Hygiene and General Therapeutics." By L. Duncan Bulkley, M.D.Lond. and New York: Rebman and Co., 1905. 8vo., pp. xv., 175.

PUBLIC HEALTH QUESTIONS. (*a*)

Undoubtedly one of the finest exercises that the intending candidate for any examination can employ, is the answering of papers set at previous examinations. This being so, we can heartily recommend this little volume to intending Public Health candidates, inasmuch as the questions contained therein are judiciously selected and so well do they cover the prescribed course, that a student who can acquit himself credibly in answering a fair proportion of them ought to have no doubts whatever as to the advisability of "sitting" for the next examination. Having finished the course of lectures and practical work, an intending candidate can pursue no better course than spend half a crown in purchasing Dr. Jones' selection of questions and answering them.

ANATOMY AND PHYSIOLOGY FOR NURSES (*b*).

There is perhaps no more disputed question connected with the training of our nurses than that dealing with the instruction which should be given in the subjects of anatomy and physiology. That some instruction is necessary almost everyone will admit, but concerning the limits of this instruction there is still the greatest diversity of opinion. It would seem obvious that those who have to learn anatomy without the aid of dissection, and without the assistance of viewing the internal organs of the body, can only be expected to acquire a very general outline of the subject. In the book before us Dr. Lewis has set forth what he considers sufficient to enable nurses "to grasp the primary principles," but we are inclined to differ with him as to what is necessary. We believe that a simple yet comprehensive statement of those principles is much more essential than a minute enumeration of sundry details. We may illustrate our point by a few quotations. Among the "review questions" which follow each chapter, we find the following:—"How many muscles are there in the pterygomaxillary region?" It is difficult to see how such a detail is necessary for a nurse who wishes to grasp the general principles of anatomy. Again, we find the question "What is respiration?" and the nurse is expected to extract the answer from the following paragraph:—"The substances furnished to the circulation from the alimentary canal are in a condition that, with reference to the atmosphere, will admit of free combination with oxygen; this latter agent is quite necessary to prepare the tissues for the functions of assimilation and nutrition. Besides this, the venous blood is also charged with carbonated products that, when exposed to oxygen, are eliminated and passed off in the form of carbonic acid gas. To effect these several purposes and thus to maintain the motive power of the system, eliminating at the same time deleterious substances, is the function of the apparatus of respiration." To us it would appear difficult to extract the meaning of the author from this passage, and we believe very few could extract from it an answer to his question.

From what has been said, it will be obvious that we differ from our author in the solution that is to be given to the question, "How far are nurses to be

(*a*) "Examination Questions for the Diploma of Public Health." By Hugh R. Jones, M.A., M.D., D.P.H. Pp. 100. Pocket size. Price 2s. 6d. net., 1906. London: Baillière, Tindall and Cox.

(*b*) "Anatomy and Physiology for Nurses." By Leroy Lewis, M.D. Philadelphia and London: W. B. Saunders and Co., 1905.

instructed in anatomy and physiology?" and even from his own point of view we cannot consider that the book has fulfilled its object. There is, however, much information in the book that will be of use to a nurse in the study of her profession, and the illustrations are excellent.

ST. BARTHOLOMEW'S HOSPITAL REPORTS. (a)

THE annual volume of reports from St. Bartholomew's Hospital is always interesting, and the present one quite maintains this reputation. Mr. John Langton, F.R.C.S., contributes an interesting memoir of the late Luther Holden, whose connection with the hospital dates from the year 1832, when he entered the medical school there as a pupil of Edward Stanley. The name of Holden has been familiar to many generations of medical students through his work on "Human Osteology," which appeared in 1855. The volume contains also many very interesting papers to which the space at our disposal will not permit us to refer more particularly. We should like to draw special attention, however, to the paper by Dr. H. H. Tooth on "The Segmental Spinal Areas Considered Clinically." This paper, which is very fully illustrated by diagrams, will well repay any physician for the time spent on its study. Bound up with this volume is the General Index of the second twenty volumes of the Hospital Reports (1885-1904), compiled by W. McAdam Eccles, F.R.C.S.

AN INTRODUCTION TO VOLUMETRIC ANALYSIS. (b)

A STUDENT beginning volumetric analysis is as likely as not very slow in grasping the fundamental principles of this branch of analysis, and the teacher capable of explaining the same must perforce be gifted with great powers of lucid expression. Again, the text-books assume, often quite erroneously, that the lectures and demonstrations are sufficient to make the subject quite clear to the student, and should the latter seek the aid of the average text-book on practical chemistry, his knowledge of the principles of volumetric analysis will not be augmented to any appreciable extent. The small volume by Drs. Walker and Mott will, we think, be a boon to both student and teacher, the instructions for the experiments and the explanations of the processes being ample to both help the student to understand and to prevent the mechanical performance of the experiments, which is the *dernier ressort* of the unfortunate student, who either cannot reason the matter out for himself, or is under the tuition of one whose verbiage is not suited to the difficult task of teaching volumetric analysis.

BIOGRAPHIC CLINICS (c).

IN the volume before us Dr. Gould adds two more to the clinical biographies which he has recounted in the previous volumes. We have here a study of the ill-health of John Addington Symonds and of Taine; in each case the explanation of the symptoms is found in uncorrected errors of refraction. Symonds died at the age of fifty-three from, we believe, pulmonary tuberculosis, which had begun more than twenty-five years before, and Dr. Gould has no difficulty in showing that many of the symptoms of ill-health which were present during this long period were not those of the pulmonary disease. As a matter of historical biography it is of great interest to find an explanation for the symptoms exhibited during their lifetime by the illustrious dead, but as a contribution to the practice of medicine it is of doubtful value. Such explanations must be at best hypothetical and must for ever remain so and consequently bring no conviction to the sceptical. Dr. Gould, however, does not entirely depend on such hypothetical proof of his contention as to the evil effects of eyestrain, for in the book before us we have many cases quoted where the clinical history was completed during the lifetime of the patient. Two papers of great interest, one by Mr. Simon Snell and the other by Mr. Ernest Pronger, are reprinted in this volume, and both of them contain the histories of many cases which prove, as far as proof is possible, the great influence of slight errors of refraction on the nervous system. We must frankly confess that Dr. Gould has convinced us by this book of the truth of his thesis and we trust that it will be widely read by medical men, believing fully that it will carry conviction to them also.

HOWELL'S PHYSIOLOGY. (a)

THE author of this text-book has endeavoured to "keep in mind two guiding principles: first, the importance of simplicity and lucidity in the presentation of facts and theories, and, second, the need of a judicious limitation of the material selected." He has certainly succeeded in producing a manual of physiology conspicuous in its clearness and as attractive as it is comprehensive. The book is divided into five main sections, and there is an appendix dealing with the chemistry of the proteids and the physics of osmosis. That part treating of the central nervous system and the special senses is very full, the physiology of sleep and fatigue having more than usual consideration. The special senses are divided into two groups—(1) the external or exterior, and (2) the internal or interior. Of the olfactory sensations, the classification by Zwaardemaker is adopted, no less than nine classes of pure odours being described. A brief reference only is made to the precipitation test for blood, but the reader is directed by a footnote to the recent work of Nuttall. The opsonic power of blood is not included in the description of immunity and the means provided by the body for combating infection from without. In the section on digestion and absorption the now well-known work of Chittenden in connection with physiological economy in diet is fully described. A few little inconsistencies, chiefly of etymology, are to be found scattered throughout the book; *e.g.*, if the term "mydriatic" be allowed, why is "miosis" retained? The student is not overburdened with references, but these are nearly always added after the introduction of recent matter or conflicting theories, the work of the principal European and American physiologists being fully drawn upon. The book is well illustrated with several coloured plates and numerous woodcuts. On the whole we can thoroughly recommend it as a reliable text-book for students or practitioners.

LABORATORY METHODS. (b)

SOME excuse is needed for the appearance of another volume devoted to laboratory methods in clinical pathology, and one consequently takes up the book under review with a certain doubt of the necessity of its existence. A very short perusal, however, is sufficient to dissipate any such prejudice, and to convince one that the book is, as might be expected from the reputation of the authors, one of great intrinsic merit. In fact, we know no book on the subject which contains so much information in so small compass. The directions given are clear and concise, and the authors have used discretion in omitting those methods that may be regarded as obsolete. It is a question whether, in a book of this sort, it is possible to treat

(a) "Saint Bartholomew's Hospital Reports." Edited by A. E. Garrod, M.D., and W. McAdam Eccles, F.R.C.S. Vol. XLI. London: Smith, Elder and Co., 1906.

(b) "An Introduction to Volumetric Analysis." By A. Jamieson Walker, Ph.D. (Heidelberg), B.A., Head of the Department of Chemistry, Technical College, Derby, and Owen E. Mott, Ph.D. (Heidelberg), Lecturer in Chemistry, Technical College, Derby. 12mo., pp. 63, 2 figures, cloth boards. (1905: London, Chapman and Hall, Ltd.)

(c) "Biographic Clinics. Volume III. Essays concerning the Influence of Visual Functions, Pathologic and Physiologic, upon the Health of Patients." By George M. Gould, M.D. London: Rebman, Ltd., 1905.

(a) "A Text-book of Physiology for Medical Students and Physicians." By William H. Howell, Ph.D., M.D., LL.D., Professor of Physiology, Johns Hopkins University, Baltimore. Illustrated. Pp. 996. Philadelphia: W. B. Saunders and Co., 1905.

(b) "Methods of Morbid Histology and Clinical Pathology." By J. Walker Hall, M.D., Lecturer in Pathology, Victoria University of Manchester; and G. Herschelmer, M.D., Prosector to the Städtisches Krankenhaus, Wiesbaden. Edinburgh; Williams, Green and Sons, 1905. Pp. xvi., 290.

bacterioscopic methods with profit, but a perusal of the thirty-three pages here devoted to the subject almost persuades us that it can be done. The chapter on Blood is good, and the most recent methods of fixing and staining are detailed. The writing is not always as careful as it might be, and some unusual words are employed. We see no reason, for example, to invent such a term as "Sectioning" to stand as title to a chapter. Some of the author's suggestions in the working of various processes had better be neglected, as when they advise to "warm the surface (of a frozen object) by rubbing it with the fingers" before attempting to cut it. These, however, are minor faults, and we have no doubt the book will speedily take its place as one of the most used in clinical laboratories.

A SYSTEM OF MEDICINE BY MANY WRITERS. (a)

We welcome with great pleasure the first instalment of a new edition of this standard work. "Though," as Professor Allbutt in his preface rightly says:—"the present work cannot be said to be out of date," it has been thought desirable to commence the publication of a new edition. The Editors have therefore arranged for the publication of a volume annually, which will re-place in turn the corresponding volume of the old edition.

The present volume consists of two parts or divisions. The first of these deals with subjects introductory to medicine, and the second with some of the acute infections. The changes which have been made amount to far more than mere revision, as a great part of the work has been re-written. The first article, on the history of medicine, is a new contribution by Professor Allbutt and Dr. Payne, and in some measure replaces the original introduction which was written by Professor Allbutt, and which has now been omitted. The article on Medical Statistics has been entirely re-written by Dr. Tatham, and constitutes a very important contribution to the literature of this subject. A new article on the medical geography of Great Britain has been contributed by Dr. Clemow. Sir Hermann and Dr. Parkes Weber contribute an article on Old Age, while Dr. Hutchison contributes a section on the physiological principles of dietetics. New articles have been added on Exercise in the Treatment of Disease, and on X-rays. Dr. F. W. Andrews has re-written the article on the General Pathology of New Growths, while additions have been made to the article on Fever by Dr. Pembrey and Dr. Hale White. Other additions of importance have also been made to many of the remaining articles.

It is neither possible nor necessary to subject an established work of the class of Professor Allbutt's System of Medicine to criticism—its length forbids, and its character excuses the absence of such treatment. It is sufficient to say that the new volume more than maintains the reputation of its predecessors in its completeness, literary characteristics, and erudition. If we may select an article from so many of high standard as being specially worthy of praise, it is that on "Inflammation," by Dr. J. G. Adami. This noteworthy contribution is so complete in itself, and treats of its subject with such minutiæ, that it may be considered rather as a monograph, which should stand alone, than as a contribution to a text-book.

The Editors expect that Volume II. will appear towards the end of the present year. It will consist of two parts, The first of these will contain the late Professor Kanthack's contribution on the General Pathology of Infection and Immunity, revised and in parts re-written by Professor Ritchie of Oxford. The second part will be devoted to Tropical Diseases. In conclusion, we may congratulate Professor Allbutt on his co-Editor, Dr. H. D. Rolleston, whose name appears for the first time on the title-page.

(a) "A System of Medicine by many Writers." Edited by Thomas Clifford Allbutt, M.D., LL.D., D.Sc., F.R.S., &c., Regius Professor of Medicine in the University of Cambridge, and Humphrey Davy Rolleston, M.D., F.R.C.P., Physician to St. George's Hospital and to the Victoria Hospital for Children. Vol. I. Pp. xvi. and 1209. London: Macmillan and Co., Ltd. 1906

CHAVASSE'S ADVICE TO A MOTHER. (a)

This justly popular volume, well remembered by many in nursery days, has been the succour and solace of many a distressed mother and has doubtless soothed and accomplished much in the sorrows of infancy and assuaged the aches and pains of helpless childhood. The anxieties of motherhood are very great and the difficulties of early days are not easy to surmount. "Chavasse's Advice," has for several generations been an inseparable companion of mothers. But while the mystery and majesty of motherhood remain ever unchanged, the progress of medicine and the advance of sanitary science makes it necessary to revise and extend even such a tried and trusted counsellor as this little domestic handbook.

Dr. Lister is to be congratulated on the wise discrimination and conscientious care with which he has accomplished the rejuvenescence of this old favourite. The old-fashioned but effectual and undoubtedly impressive catechetical arrangement is retained, and the same familiar fatherly dogmatic directions are given, but withal there is an up-to-dateness and modernity which is refreshing. We are glad to find that Dr. Lister does not hesitate to condemn old-time dangerous procedures born of ignorance and superstition. This is particularly noticeable in the sections dealing with the administration of alcohol to nursing mothers and children.

In some quarters it is fashionable to ridicule such an eminently mother's book as this. It is one, however, which, rightly viewed, instead of replacing the family doctor, should do much to indicate his necessity and assist in the very purpose for which he exists.

We unhesitatingly commend this homely volume. It is a work which many a newly qualified practitioner, and, indeed, some rusty and old-fashioned family physicians, might well study with advantage both to their professional reputations and the health and happiness of their little patients.

PUERPERAL FEVER. (b)

When Dr. Cullingworth gave his address on "Oliver Wendell Holmes and the Contagiousness of Puerperal Fever" to the Bath and Bristol Branch of the British Medical Association last October, we congratulated him on his choice of a subject. We are glad, therefore, to see this reprint of the lecture enforced by appendices on related subjects. There is no more interesting chapter in the history of medicine than that which relates to the progress of our knowledge of puerperal fever, and in this chapter two names stand out above all others—Holmes and Semmelweis. Not even to Pasteur and Lister do we owe so much in this particular respect. It is true that Holmes had predecessors, among whom the chief are White, of Manchester and Gordon, of Aberdeen, but Holmes was the first to marshal his facts in logical order, and to move his battalions into action as in a great warfare. Be it said, too, that although his essay was published in April, 1843, it could not be improved to-day by the addition or subtraction of a line—leaving out of account, of course, arguments based on bacteriological study, which has sprung into existence since that time. The essay is, indeed, one of the classics of medicine, and Dr. Cullingworth does not exaggerate when he compares its noble and fervid eloquence to that of the Hebrew prophets. Speaking of it, the author himself once said, "for doing which humble office I desire to be thankful that I have lived, though nothing else good should ever come of my life." Much good has come of Holmes's long, laborious, and distinguished, life, but nothing greater than his "battle for the poor poisoned women."

(a) "Chavasse's Advice to a Mother on the Management of her Children and on the Treatment of the Moment of some of their more pressing Illnesses and Accidents." 16th edition. Revised and largely re-written by Thomas David Lister, M.D. Lond. Pp. viii., 454. London: J. and A. Churchill. 1906. Price 2s. 6d.

(b) "Oliver Wendell Holmes and the Contagiousness of Puerperal Fever." By Charles J. Cullingworth, M.D., F.R.C.P., &c. London: Henry J. Glaisher. 1906. Price 2s. 6d. net.

MEDICAL NEWS IN BRIEF.

Presentation to Dr. Coleman.

ON July 24th, a deputation of the leaders of the medical profession in Ireland presented Dr. Coleman with a resolution signed by 1,300 medical practitioners in reference to recent legal proceedings. The gentlemen who presented the resolution were the Presidents of the Royal Colleges of Physicians and Surgeons; Sir Arthur Chance, Sir Christopher Nixon, Bart., Sir Francis Cruise, Sir Wm. Thomson, Sir Arthur Macan, Dr. J. Magee Finny. The President of the College of Physicians (Sir W. Smyly) occupied the chair, and in addressing Dr. Coleman, said for a long time his brethren of the medical profession had felt with the most earnest solicitude the course of events in which he (Dr. Coleman) had been so deeply concerned. And although those of the profession who had known him personally never for a moment had a doubt as to his innocence of the charges which were brought against him, yet they could not but feel that it was a matter for thankfulness and for congratulation that he was able to refute those charges and that the jury and the judge had declared that he had passed through that terrible ordeal without a blemish on his professional or private character. Under these circumstances, it was not only proper, but was most fitting that they, his medical brethren, should have an opportunity of expressing to him their sentiments. As to their authority for so doing, he might explain that they, as Presidents or vice-presidents of the Royal Colleges of Medicine and Surgery, had been deputed by a large and representative meeting of the medical profession, assembled in Dublin, to convey to him a resolution signed by upwards of 1,300 of his brother practitioners throughout the country. The following was the resolution:—"That we, the professional brethren of Dr. James Byrne Coleman, congratulate him on the successful manner in which he has recently refuted the unfounded charges brought against him and express our sympathy with him in the trouble through which he has passed without blemish on his character or honour." Mr. H. R. Swanzy, as President of the Royal College of Surgeons and all that it represented desired to associate himself with the words which had been spoken by the President of the College of Physicians. He could assure Dr. Coleman that from the moment they first learned of the nature of the charges made against him they felt that he could be nothing but innocent of them; but their hearts went out to him in sympathy. This was no light-hearted sympathy, nor was it a restricted and unconsidered one; but it was not at all difficult to see the grounds upon which they founded their opinion. For many years, almost, they might say, since Dr. Coleman came to manhood, he had been under their observation as student, as house surgeon, and as physician in a great public hospital, as a practitioner of medicine in their midst. They had thus ample opportunities of learning his character. They knew the kindness of heart, they knew him as a skilled and gentle and well-beloved physician, full of sympathy for the sufferer, and unfailing in courtesy to him. The album containing the resolution, with 1,300 signatures, was then presented.—Dr. Coleman, in replying, said—Gentlemen, I thank you from my heart for the very great honour which you, the leaders of the medical profession in Ireland, have conferred on me here to-day, in conveying the resolution which has been read, and I thank the President of the College of Physicians and the President of the College of Surgeons for the all too kind words in which they have referred to me. I am grateful beyond measure to the signatories of the resolution for the kind spirit which prompted them to express their sympathy with me in my great trouble. Such a manifestation of confidence and of sympathy is of priceless value to me, and it gives me new courage to take up again the threads of my broken life. Gentlemen, I shall never forget your great kindness to me; and all I can do is to give expression in this very inadequate way to my feelings of gratitude to you, and my sincere thanks to you. The proceedings then terminated.

"Bile Beans" Appeal.

THE appeal of the "Bile Beans" Company against the ruling of the lower court, which had refused to protect their trade-mark, was dismissed in the Court of Sessions on July 22nd. In delivering judgment the Lord Justice-Clerk said bile beans were said to be made of Australian vegetable substances discovered by a Charles Forde. The place of the discovery, the mode of it, and the instrument of it were all deliberate inventions, without any foundation in fact. The story was that Charles Forde, described as a skilled scientist, had noted the fact that the natives of Australia were free from bodily ailments, and that after research and investigation he had ascertained that that immunity was obtained by the vegetable substances. All that, in every particular, was false. There was never such a person as Charles Forde, and there was no eminent scientist engaged in such research in Australia. The truth was that the complainers had formed a scheme to palm off upon the public a medicine obtained from America, and they created a demand by flooding the country with advertisements, placards, pamphlets, and imaginary pictures. The complainers desired protection for the name "Bile Beans," but being themselves engaged in perpetrating a fraud upon the public, they were not entitled to any such protection.

The Criminal Appeal Bill.

THE following resolution has been passed by the Criminal Law and Prison Reform Department of the Humanitarian League, and copies have been forwarded to Sir Henry Campbell-Bannerman and Mr. Herbert Gladstone:—"This Committee of the Humanitarian League would earnestly impress upon His Majesty's Government the importance of passing the Criminal Appeal Bill during the present session of Parliament, as we believe that the Bill would receive the support of an overwhelming majority of the House of Commons. We regret to see no improvement in the Criminal Department of the Home Office, whose defects as an appellate tribunal are now generally recognised. On the contrary the number of miscarriages of justice corrected during the present year has so far been unusually small; and we submit that the creation of a properly-constituted Court to re-try criminal cases ought to be regarded as a matter of the utmost urgency."

London Temperance Hospital.

A PARTICULARLY pleasing incident took place last week at the meeting of the Board of Management of the London Temperance Hospital, when the matron made a presentation to the Board on behalf of the nurses. The Board are under the necessity of erecting a new building for their Out-patient and Casualty Departments, and have found some difficulty in raising the £10,000 involved. The present nurses, together with a few past nurses, have among themselves collected £130 towards this object, and the Matron found a purse containing this sum and a card with the following inscription upon her table, on the morning following her return from her summer vacation: "To Matron, the enclosed £130 for the new Out-patient Department, from the present and a few past nurses of the London Temperance Hospital, in token of their affection for their training school." The members of

the Board were very much gratified and impressed by this kindly token of sympathy and interest by the nursing staff, and adopted a special resolution to record the event on the minutes of proceedings.

PASS LISTS.

Royal Colleges of Physicians and of Surgeons, England.

The following are the names of the fifteen candidates who have been recommended by the Examiners for the Diploma in Public Health, viz. :—John Howard Cumpston (Melb. & Univ. Coll.), Lancelot Hugh Hale (St. George's), John Molyneux Hamill (Camb. & St. Barth.'s), Jonas William Leake (Charing Cross & R.A.M.C.), Hugh Allan Macewen (Glasgow), Sidney Herbert Nathan (Camb. & St. Geo.'s), Lionel Edmund Parker (St. George's & R.A.M.C.), Thomas Phare Puddicombe (St. Thomas's & King's Coll.), Daniel Macpherson Taylor (Glasgow & Leeds), John Francis Taylor (London & Univ. Coll.), William John Thomas (Middx. & Cardiff), Jack Mowbray Thomson (Sydney & Univ. Coll.), Henry Beckles Walton (St. Mary's, Netley, and Univ. Coll.), Hugh George Webb (St. Mary's, R.A.M.C., and London), Charles Savill Willis (Sydney & Univ. Coll.)

The Court also recommended that the Diploma of Member be issued to the 103 Candidates whose names are included in the following list, viz. :—Charles Amarasuriya, Lorimer John Austin, George Frederick Selborne Bailey, George Charles Barnes, Richard Dunlop Barron, Winfred Kelsey Beaman, Norman Bennett-Powell, Harold Bevis, Lionel Hethorn Booth, Walter Henry Skardon Burney, John Butterworth, Norman Huthnance Bye, John Graham Castellain, Fredk. Hercy Montagu Chapman, Betram Walter Cherrett, Thomas Alexander Clarke, Bevil Molesworth Collard, David Horace Collingham, Harold Percy Crampton, Henry Neville Crowe, Samuel Wilfrid Daw, Joseph Taaffe de Coteau, William Frederic Denning, Gurth Eager, Kenneth Edward Eckenstein, Rupert Farrant, William Stephen Fenwick, Alexander Fleming, Robert Long Gamlen, Nadir Hormazshaw Gandhi, Henry John Gauvain, Ernest William Giesen, Vivian Bartley Green-Armytage, Cyril Verity Griffiths, Edward William Dacre Hardy, George Atkin Hayman, John William Heekes, Reginald Beaumont Heygate, Carl Cornelius Hickey, Richard Athelstane Parker Hill, Richard Chambers Hill, Joseph Henry Howitt, Godfrey Martin Huggins, Cyril Bertram Hutchison, Claude Johnson, Alfred Lancelot Jones, Harold Emlyn Jones, James Reginald Kemp, Charles Matheson Kennedy, James Armstrong Kilpatrick, Alexander Kinder, William Wilfrid King, Basil Thorn Lang, Crichton Stirling Lee, David Thomas Lewis, Percy Collins Litchfield, Patrick Francis McEvedy, Charles McMane, Herbert Cecil Malleson, William Burton Marshall, Vernon Lickfold Matthews, Edward Meredyth Middleton, William Henry Miller, William Arnold Milner, William Cecil Morrison, Albert Clifford Morson, Herbert William Moxon, Frederick William Murray, Charles Melton Ockwell, Hubert Arnold Pallant, John Paulley, Henry Austin Philpot, Constant Wells Ponder, Joseph Marshall Postlethwaite, Edgar Nelson Ramsbottom, Allan Coats Rankin, Hubert George Rickman, Charles Sangster Rivington, Richard Pugh Rowlands, Harold Kenneth Salisbury, Gerald Claude Scott, George Elliott Seldon, Edward Fretson Skinner, Alexander Buchanan Smillie, Walter Heaton Smith, George French Stebbing, William Hugh Raymond Streatfeild, Pheroze Kharsedji Taraporwala, Reginald Thane Taylor, Edmund James Fairfield Thomas, Robert Evans Thomas, Arthur William Dunville Thomson, Frederick Boileau Treves, Sydney Arthur Tucker, Stuart William Jackson Twigg, Harold Arthur Robert Edmund Unwin, Rubens Wade, Kenneth Macfarlane Walker, John Black Ferguson Wilson, Alfred William George Woodforde, John Charles Wootton, Ernest Wragg, Everard Lister Wright.

University of Aberdeen.

At the graduation ceremony on July 25th, the following degrees were conferred :—

Degree of Doctor of Medicine (*M.D.*).—*Hugh Stewart Brander, M.A, M.B., Ch.B. ; *Alexander Flett, M.B., Ch.B. ; James Gilchrist, M.A., M.B., Ch.B. ; Alexander Gregor, M.B., C.M. ; David Mitchell Macdonald, M.B., Ch.B. ; Wyndham Anstruther Milligan, M.A., M.B., C.M. ; Alex. Murchison, M.B., C.M. ; Maurice Waugh Renton, M.B., C.M. ; Harold Traill Skae, M.B., Ch.B. ; †Wm. Clark Souter, M.B., Ch.B.

Degree of Master of Surgery (*Ch.M.*).—Isaac Frederick Bernhardi de Villiers, M.B., Ch.B.

Degrees of Bachelor of Medicine (*M.B.*) *and Master in Surgery* (*C.M.*).—Lawrence Cartwright, Thomas Robert Travell.

Degrees of Bachelor of Medicine (*M.B.*) *and Bachelor of Surgery* (*Ch.B.*)—‡Roderick McKenzie Gunn, (with Second Class Honours). Ordinary Degree—Henry Begg, William Begg, Francis James Browne, Robert Chalmers, James M'Killican Clark, George Cooper, James George Copland, M.A., William Dalgliesh, Hubert Karl W. H. Dornhorst, Robert James Duthie, Theodore Grant Gray, Alfred Petrie Hall, George Frederick John Hendry, James Laing, M.A., James Meajns Macdonald, James Ross Mackenzie, Robert William MacPherson, Douglas John Marr, Alexander Noble, Alexander Paterson, M.A., Patrick Manson Rennie, Albert Nathaniel Ewing Rodgers, George Ernest Ross, M.A., James Arthur Scharenguivel, Henry Smit, Charlotte Augusta F. S. Sturm, Alexander Frank Wallace.

Note.—James Elmsly Mitchell has passed all the examinations, but will not graduate until he has attained the necessary age.

*Commendation for Thesis.

†Honours for Thesis.

‡Passed Final Examination with distinction.

The Lyon Prize (awarded to the most distinguished graduate in Medicine of the year ; and the *John Murray Medal and Scholarship* were won by William Alexande Hogg M'Kerrow, M.B., Ch.B., of Workington.

The Alexander Anderson Scholarship was awarded to James M'Intosh, M.B., Ch.B., of Aberdeen.

The Diploma in Public Health was granted to Charles Butchart Gerrard, M.B., Ch.B. Aber. of Aberdeen. Presentation to Dr. Steede.

Indian Medical Service.

The following were the successful candidates at the examination for admission to the Indian Medical Service, held on July 24 and four following days:—J. Taylor, M.B., A. D. Stewart, M.B., C. H. Cross, R. A. Chambers, M.B., R. H. Bott, F.R.C.S., N. N. G. C. McVean, M.B., J. Morison, M.B., S. G. S. Haughton, M.B., F. W. Cragg, M.B., N. S. Simpson, S. Singh, R. F. Hebbert, M.B., J. F. James, M.B., J. Smalley, M.B., A. S. Leslie, M.B., C. M. Roberts, M.B., A. P. G. Lorimer, M.B., W. M. Thomson, M.B., H. B. Scott, F. C. Fraser, M.D. Forty-seven candidates, thirty-two of whom had University qualifications and five Fellowships of the Colleges of Surgeons, competed for the twenty vacancies. A few extra vacancies will probably be given in the course of the next few days.

The Royal Colleges of Physicians and Surgeons of Edinburgh, and the Faculty of Physicians and Surgeons of Glasgow.

At the July sittings, held in Glasgow, the following candidates passed the final Examination and were admitted licentiates of the three co-operating authorities :—James Henry Allan, Liverpool ; Owen Thomas Jones, Bangor, North Wales ; Robert John Jones, Penygroes, North Wales ; James Alfred Ashurst, Govan ; Gavin Watson Hill, Hamilton ; John M'Arthur, Newmains ; Ratilal Rangildas Bakshi, India ; Adam Hill, Ballymoney, co. Antrim ; Edward John Stubbs, Stratford, Ontario ; Ernest Clinton Chandler, Montreal ; Lakshmipati, India ; Lawrence Albquerque, India ; Mahomed Samiullah, India ; Patrick John Alexander Curtin, India ; Andrew Baxter, Essex ; Jalibai Bomanji Engineer, Hyderabad ; Ronald Archibald Taylor, London.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS. ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT GYNÆCOLOGICAL AND OBSTETRICAL LITERATURE.

Puerperal Sepsis.—Jackson (*American Journ. of Obstet.*, July, 1906) says why an obstetrical case should not be conducted with the same regard for asepsis as a surgical case is a mystery, but oftentimes they are not. The writer, therefore, insists on a strict prophylaxis, consisting of surgical cleanliness on the part of the doctor and everything that is to come into contact with the patient. Make the whole procedure a surgical one, and impress the patient and the family of its import. Dispense with antepartum douching unless in the face of necessity. Wear rubber gloves; make no vaginal examinations after the birth of the child unless there is an absolute reason. Suture any perineal wound, leaving wounds of cervix alone unless compelled by hæmorrhage. Make as few vaginal examinations as possible, careful abdominal palpation is better, and there is no danger of infecting the patient. Do not allow the child to be forced between a loaded bladder and rectum. If the lochia is foul, profuse and frothy, examine the cavity of the uterus with your finger and have a bacteriological examination of the lochia if it can be done. The wall will usually be rough, and the cavity filled with blood clots, secundines, or some *débris* that should be removed. Preferably this *débris* should be removed by the finger, but if the curette is used great care should be exercised not to destroy the granulation zone; finish then with a saline douche given gently. If the symptoms are those of true sepsis, the above-mentioned treatment is not to be used. Above all things do not curette; it is no less than criminal. Not only is the incomplete protective zone destroyed, but the infection is spread. Do not weaken the patient by purges, but dilute the poisons with normal salt solution per rectum, subcutaneously or intravenously. As local treatment the author recommends "the alcohol method," which is carried out as follows: Lift the patient on to a table in a good light; carefully clean the vulva and vagina by soap, water, alcohol, and a 2 per cent. eysol solution; mop and dry vagina, and insert a Sims' speculum. The cervix is seized in a vulsellum, and cervical canal is cleaned by means of gauze. The uterine cavity may be irrigated with a normal saline solution, or wiped with pure carbolic in case of a membrane being present, and then dried with gauze. A double current drainage tube is then introduced to the fundus, and a solution of 50 per cent. alcohol is thrown through the tube with a glass syringe. The vagina is now packed lightly with gauze, and the nurse is directed to inject from two to four ounces of the 70 per cent. alcohol through the tube every few hours. This will not only cleanse the cavity, but will act as a powerful non-toxic antiseptic. F.

Pelvic Pain.—Bonney (*Annals of Gynæcol.*, March, 1906) says the three most common causes of pelvic pain are backward displacements, prolapse, and disease of the appendages. The pain of retroversion and retroflexion is referred to the sacrum, and there is often further pain radiating outwards across the front of the lower abdomen and parallel with Poupart's ligament. This pain is modified by dorsal decubitus, but not entirely relieved. The pain due to prolapse is primarily referred downwards through the vagina, and is of a "bearing down" character. The pain is also referred to the sacrum and lower abdomen. It is instantly relieved by recumbency. The pain due to chronic disease of an appendage is felt in the lower abdomen, radiating outwards parallel with Poupart's ligament, and is conspicuously not modified by recumbency. Indeed, it is often worse at night. In examining women for the cause of alleged abdominal pain, it is very important to investigate the condition of the kidney. F.

Serum Treatment of Puerperal Fever. — Peham (*Archiv. f. Gynakol.*) records and analyses cases of puerperal fever treated with Poltauf's serum in Vienna. These experiments prove that puerperal infections caused by streptococci are influenced by the administration of this serum, however severe the infection may be. The influence of the serum depends upon its administration at the earliest possible moment, and upon the use of relatively large doses. In disease of long duration and in the presence of serious organic lesions the serum is powerless. It would seem, also, that it is unable to prevent the advance of localised suppuration processes such as metastatic abscesses. The serum does not produce any bad effects even in those cases in which the disease is due to infection by organisms other than streptococci. F.

Bacteriological Investigations of Operation Wounds: Concerning their Infection, with a New Proposal for its Prevention.—Döderlein, Tübingen, communicated during the 35th Surgical Congress (*Zentralbl. f. Gyn.* No. 27, 1906) the results of bacteriological examinations of the field of operation during 100 laparotomies. In spite of the most thorough asepsis, combined with the use of rubber gloves, face masks, Küstner's rubber towel for covering over the field of operation, etc., the abdominal cavity as well as the abdominal wound was found to be septic at the end of operation in every case. Döderlein believes therefore, in conjunction with Brunner, Schenk and Lichtenstern, that the skin around the area of operation is the principal source of infection in operation wounds. For laparotomies, therefore, the skin of the abdominal wall must be considered, and in order to prevent it giving out its bacteria, he recommends the following treatment: After the usual preparation of the patient, thorough baths, shaving, etc., the skin around the field of operation and the surrounding parts is rubbed over immediately before the operation with formalin-benzine or iodine-benzine (Heussner), and then painted with pure tincture of iodine. Over the latter a very carefully sterilised rubber solution is spread. By this means a rubber membrane firmly attached to the skin is produced. The rubber solution on the skin dries after a few minutes owing to the evaporation of the benzine, and its adherent properties are increased by sprinkling it with sterilised chalk. We have now a thin, smooth, sterile rubber membrane firmly attached to the skin, which all through the operation absolutely prevents the skin from giving up its bacteria. Numerous cultures demonstrated by the speaker showed the absolute freedom from infection in operations performed with this protection. He said in conclusion that by thus preventing this last source of infection, Lister's ideal of absolute cleanliness is reached. G.

Deprivation of Salt in Cases of Hydrops Gravidkatis is discussed by Cramer (*Monatssch. f. Geb. u. Gyn.* Bd. 23, Hft. 4). He sums up his paper as follows: The œdema is caused by a toxic disturbance of the eliminating powers, and its disappearance may be brought about by not giving salt in the food. The frequently observed œdema of the lower extremities occurring during pregnancy is not due to obstruction but to gravity, and can only appear when the hydrops has reached a certain limit. A direct connection between the hydrops graviditatis and the kidney of pregnancy of Leyden is not proved, since albuminuria is observed

when the œdema is disappearing or has not been present. It is necessary to replace the usual term, "the kidney of pregnancy" with "the albuminuria of pregnancy," and the conception of the kidney of pregnancy must be increased so as to include the disturbances of the kidney function which occur without causing albuminuria. The clinical definition of eclampsia requires alteration in the same way, since we must recognise eclampsia without convulsions. We also observe eclampsia without œdema. At the same time the combination of hydrops, albuminuria and eclampsia is a common one. The author cannot say for certain that the deprivation of salt has any ill effect on the development of the ovum. G.

The Prophylaxis and Radical Cure of Post-Operative Ventral Hernia.—Schutze (*Monatssch f. Geb. u. Gyn.*- Bd. 23. Hft. 4) is driven to the opinion that the incision in the middle line in the linea alba protects the tissue of the abdominal wall to the greatest extent. It requires the shortest time and promises just as firm a scar as the vertical incision outside the middle line or the transverse incision. The wound in the fascia unites so thoroughly when the suturing is properly done that the fascia recovers its normal firmness. The best suture material is antiseptic silk (Turner's). The condition of the abdominal walls whether they are firm or lax, fat or thin, has no influence on the later resisting power of the scar. Pregnancies and deliveries cannot produce separation of a really well consolidated fascia-scar. The methods of Gottschalk, Winter and Karewski are the best for the radical cure of post-operative ventral hernia. G.

The Treatment of the Placental Stage is considered by Strassmann (*Zeitsch. f. Geb. u. Gyn.*, Bd. lvii, Hft. 2). He says when a placenta is still attached to the uterus gentle pressure on the fundus uteri fills the umbilical vein strongly with blood, so that the hand holding the cord feels a fluctuation wave in the vein. After separation of the placenta one does not get this sign any longer. The placenta should not be expressed before 30 minutes post partum except all the signs of separation are present. If the latter are not present one must wait, and the attempt to express must not be repeated oftener than every half hour. After artificial delivery the hæmorrhage from the different small tears is no indication for immediate delivery of the placenta. In practice the placental stage must not be considered as completed when the placenta is born. The physician must watch the uterus for at least half an hour, and then express any blood-clots in the uterus or in the vagina. After manual removal of the placenta or portions of it, the uterus and vagina need not be washed out at all, or one may use sterile saline or weak lysoform solution. In any case antiseptics and alcohol should be used with care on account of the danger of absorption. G.

X-Ray Burns.—At the 337th regular meeting of the New York Dermatological Society the subject of X-ray burns was taken up, and Dr. Henry G. Piffard, Emeritus Professor of Dermatology in New York University, said, according to the *Journal of Cutaneous Diseases*, "that he had obtained the most benefit in treating these conditions from antiphlogistine, chloride of zinc, high frequency current and ultra violet rays."

Spontaneous Rupture of Hydrocephalus.—A case is recorded by Veninger (*Wien. Med. Woch.*, February) in which rupture of a hydrocephalic head took place. The child appeared normal at birth with the exception of a slight degree of spina bifida, at the lower end of the sacrum, a small sinus led into this spinal protrusion, and from the sinus a little cerebro-spinal fluid escaped for two or three days, then ceased, and the opening closed. At once the head began to enlarge, and soon became to a marked degree hydrocephalic. While the infant was being gently lifted, the head suddenly burst, some three litres of clear fluid coming away. The head resembled a large flaccid bag. It is interesting to note that the infant rapidly recovered from the shock of this accident, and seemed none the worse for some seven days; on the eighth day profuse diarrhœa set in and the child died. G.

Rupture of the Uterus.—Rowstron (*Brit. Med. Journ.*, July 7th, 1906), describes a case of this complication which occurred in his practice. The patient was a thin, ill-nourished woman, pregnant for the third time, æt. 28. When first seen, the pains occurred every ten minutes, moderate in type. The membranes were ruptured, and the os not quite fully dilated. The child presented as a first breech. When seen again an hour and a quarter later the pains were very strong, but the breech had made no advance. Chloroform anæsthesia was induced and the legs brought down and half an hour later the body was delivered. Friction was then applied to the legs and body but proved ineffectual, the pains meanwhile passing off and stopping altogether at the end of another half-hour. The pulse was then 100. Abdominal palpation revealed part of a fœtal head to the left and below the umbilicus, and as the sutures were felt with the greatest ease through the abdominal wall, the uterus was judged to be ruptured. The question then presented as to whether delivery should be ejected via the abdomen or vagina. Since the larger portion of the head had not yet passed through the rupture the latter route was chosen. Forceps were applied to the after coming head and the child—with hydrocephaly and spina-bifida, was delivered. An abdominal section was rapidly performed and the rent closed in two layers. It was 3½ in. in length and lay in the left posteriolateral region involving the fornix and whole length of cervix. The patient's condition was such that she succumbed four hours after the operation. There had been a quantity of clot and fresh blood in the peritoneal cavity. H.

An Anencephalic Monster.—Edwards, Penzance, June 30th, 1906 (*Brit. Med. Journ.*)—A primipara, æt. 19, was delivered of an anencephalic fœtus which survived birth for forty-eight hours. Its weight was 7 lbs., and length 20 in., and in appearance was well nourished. The cranial bones could be felt ending abruptly. The vertex was covered with hair, save in the middle line, where an irregular mass of brain matter protruded through. When slight pressure was made on this mass, rhythmical movements were set up, of the head, body, and limbs. The mass bled easily and there was a constant dribbling away of cerebro-spinal fluid. The only other malformation was absence of any urethra. H.

Excision of the Superior Cervical Ganglion in Inflammatory Glaucoma.—Dr. M. Lanckton Foster (*Annals of Ophthalmology*, October, 1905) reports a case which commenced as simple glaucoma, and in spite of treatment by eserine progressed until about six months afterwards, when an acute attack supervened for which an iridectomy was performed, but without relief. Eventually the superior cervical ganglion was removed, but the eye continued painful and vision fell to 0. From this case Foster concludes that the presence of inflammatory symptoms of the faintest degree indicates a local condition of the eye productive of glaucoma, which is not dependent on the sympathetic nervous system; while, on the other hand, when we have cases of simple glaucoma which are materially influenced by the removal of the superior cervical ganglion, as indicated by the cases published, we must suppose we are dealing with cases of quite a different nature from chronic inflammatory glaucoma, as maintained by v. Graefe. Foster thinks that most of the published cases were reported after the lapse of too short a time after the operation to permit of reliable deductions as to the permanency of the success. M.

Note.—*A Summary will appear each week in the following sequence:*—(1) "*Recent Medical Literature.*" (2) "*Recent Surgical Literature.*" (3) "*Recent Gynæcological and Obstetrical Literature.*" (4) "*The Recent Literature of Physiology and Pathology.*"

NOTICES TO CORRESPONDENTS, &c.

☞ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to 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 proofs.

CONTRIBUTORS are kindly requested to send their communications if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

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.

DR. L. T. O.—We cannot advise without being furnished with the full facts of the case. If our correspondent will communicate with us again we will go into the case and report.

X. Y. Z.—There is no public institution of the kind that we know of. The Secretary of the Charity Organisation Society might be able to help our correspondent.

MR. SIMMONDS.—There is nothing unethical in the method proposed to be adopted.

BRADFORD.—The matter should be referred to a solicitor, without delay.

M.D.—The reason is that the parasitic theory of cancer, that is to say malignant disease, is regarded by the best authorities as dead.

SPES.—The answer, unequivocally, is in the negative.

T. B. W.—The latest example is that of Leeds. The public analyst reported that for the quarter ending June 30th out of fourteen samples of butter no less than seven consisted almost wholly of foreign fat.

L. F.—A Paper on "Hernia Through the Foramen of Winslow," by Faure, in the "Bulletin et Mémoire de la Société de Chirurgerie de Paris," No. 12, 1906, gives a capital criticism of the subject.

S. R.—There is a paper on the subject by Drs. Meakin and Wheeler in the *British Medical Journal*, for Nov. 25th last. It will hardly answer all the points you raise, but as the question is yet in its infancy one must suspend judgment.

R.A.M.C.—We can hardly keep pace with the various phases of that blessed word, "mobilisation," but we understand that according to the last plan (Mr. Haldane's) the Nursing Staff will expand automatically with the requirements of the R.A.M.C. A question in Parliament could easily be arranged by one of the Service Members, and might do good by drawing attention to the subject.

T. M. A.—The late Dr. Mark Antony MacDonnell was brother to Sir Antony MacDonnell. He did not practise, we believe, for many years before his death.

F. N. T.—Such a rumour is hardly worthy of notice, but if you are a member of the Medical Defence Union, a letter would probably be written by them on your behalf if the facts were laid before the Council. On the whole, however, we should advise you to wait for a week or two. You will probably hear nothing more of it.

L.D.S.—If you give gas for an unregistered dentist you may probably be charged with "covering." We strongly warn you not to do so. If an unregistered dentist chooses to practise he must settle his own difficulties, and it is not contrary to the humanitarian principles of the profession for you to refuse to help him and his patients, always excepting, of course, grave emergencies of life and death.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, AUGUST 1st.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—10 a.m. Dr. Ball: Diseases of the Throat, Nose, and Ear. Dr. Saunders: Diseases of Children. 2 p.m. Medical and Surgical Clinics. 2.30 p.m. X-Rays. Operations.

CENTRAL LONDON THROAT AND EAR HOSPITAL (Gray's Inn Road, W.C.).—5 p.m. Demonstration:—Mr. Stuart-Low; Ear.

THURSDAY, AUGUST 2nd.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—2 p.m. Medical and Surgical Clinics. 2.30 p.m. X-Rays. Operations. Mr. Dunn: Diseases of the Eye.

FRIDAY, AUGUST 3rd.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—10.30 a.m. Dr. Moullin: Gynæcological Operations. 2 p.m. Medical and Surgical Clinics. 2.15 p.m. Dr. Ball: Diseases of the Throat, Nose, and Ear. 2.30 p.m. X-Rays. Operations. Dr. Abraham: Diseases of the Skin.

SATURDAY, AUGUST 4th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—10 a.m. Dr. Ball: Diseases of the Throat, Nose, and Ear. 2 p.m. Medical and Surgical Clinics. 2.30 p.m. X-Rays. Operations.

Vacancies.

Egyptian Government.—Ministry of Education.—Professor of Midwifery and Gynæcology. Salary £400 a year, with private practice. Applications to the Director, School of Medicine, Cairo, Egypt.

Egyptian Government.—Ministry of Education.—Medical Tutor and Registrar to Kasr-El-Ainy Hospital. Salary £400 a year. No private practice. Applications to the Director, School of Medicine, Cairo, Egypt.

Manchester Royal Infirmary.—General Superintendent and Secretary. Salary £600 per annum. Applications to the Chairman of the House Committee, Royal Infirmary, Manchester.

Sheffield Union Hospital.—Resident Medical Officer. Salary £100 per annum, with apartments, rations, &c. Applications to Albert Edward Booker, Clerk to the Guardians, Union Offices, Westbar, Sheffield.

Weston-super-Mare Hospital. — House Surgeon. Salary £100 per annum, with board and residence in the Hospital. Applications to the Honorary Secretary.

Wolverhampton and Staffordshire General Hospital.—Assistant House Surgeon. Salary £75 per annum, with board, lodging, and washing. Applications to J. Stephen Neil, House Governor and Secretary.

Bracebridge Asylum, Lincolnshire.—Senior Assistant Medical Officer. Salary £150 per annum, with furnished apartments, board, attendance, and washing. Applications to the Clerk to the Visitors, W. T. Page, Jun., Esq., Bank Street, Lincoln.

Essex and Colchester General Hospital.—House Physician. Salary £80 per annum, with board, residence, and washing in the Hospital. Applications to Alfred G. Buck, Secretary, the Hospital, Colchester.

The Choriton and Manchester Joint Asylum.—Resident Medical Officer. Salary £120 per annum, with board and residence. Applications to Henry Woodhouse, Clerk to the Joint Committee, Choriton Union Offices, All Saints, Manchester.

Sussex County Hospital, Brighton.—House Physician. Salary £70 per annum, with board and residence in the Hospital, with washing. Applications to the Secretary.

Corporation of Manchester.—Monsall Fever Hospital.—Fourth Medical Assistant. Salary £100 per annum, with board, lodging, and washing. Applications to the Chairman of the Sanitary Committee, Public Health Office, Town Hall, Manchester. Wm. Henry Talbot, Town Clerk, Public Health Office, Town Hall, Manchester.

Galway Hospital.—Resident Medical Officer and Compounder of Medicine. Salary £75 per annum, with apartments and rations. Applications to S. J. Leonard, Clerk.

Appointments.

ESKELL, L. B., L.D.S., R.C.S.I., Honorary Dental Surgeon to the Winsley Sanatorium for the Consumptives of the Counties of Gloucester, Somerset, and Wiltshire, and the City and County of Bristol.

GOODE, CHRISTINA L., M.B., B.S.Melb., Assistant Medical Superintendent to the Leytonstone Infirmary.

KERRAWALLA, M. P., M.D.Brux., L.R.C.P. and S.Edin., L.M. and S. Assistant House Surgeon to the Hastings, St. Leonards, and East Sussex Hospital.

MOULD, G. T., Major, I.M.S. (retired), Refraction Assistant at the Royal London Ophthalmic Hospital (Moorfields Eye Hospital).

NOALL, W. PAYNTER, M.S.Lond., F.R.C.S.Eng., Clinical Assistant to the Chelsea Hospital for Women.

PORTER, CHARLES, M.D.Edin., Assistant Medical Officer of Health of Leeds.

WALKER, THOMAS WARBURTON, M.B., Ch.B.Vict., Medical Officer to the Workhouse by the Tetbury (Gloucestershire) Board of Guardians.

Births.

GONIN.—On July 29th, at Courtlands, Burstow, Surrey, the wife of E. H. Gonin, M.D., of a daughter.

PURVIS.—On July 21st, at 14 Carlton Crescent, Southampton, the wife of Dr. William Prior Purvis, of a daughter.

Deaths.

COLLINS.—On July 27th, at Hawthorn Lodge, Yapton, John Boniface Collins, M.R.C.S., L.S.A., aged 81 years.

JONES.—On July 25th, at Bron-y-graig, Corris, Merioneth, in his 69th year, John Thomas Jones, M.R.C.S.

TAYLOR.—On July 26th, at Hilldrop, Stevenage, Herts, Deputy-Surgeon-General Edward Taylor, H.M. Bengal Army (retired), aged 81.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIII. WEDNESDAY, AUGUST 8, 1906. No. 6.

NOTES AND COMMENTS.

Irish Successes in the Army Medical Service Examination.

THE results of the recent examination for commissions in the Royal Army Medical Corps must prove a matter for congratulation to all upholders of the Irish Medical schools. An analysis of the list shows that forty commissions were given, and that of these seven were won by Scottish graduates, thirteen by English graduates, and twenty by Irish graduates. If the list of successful Irish candidates is then examined, it will be seen that three of them obtained their degrees from the Royal University, eight from the Conjoint Royal Colleges, and nine from Dublin University. In view of the fact that on several recent occasions the Trinity College Medical School has been held up to public obloquy as an institution run by an illiterate little coterie, it is interesting to note that at an outside examination its graduates have obtained almost a quarter of the total number of commissions awarded. The Conjoint Colleges have also been the subject of criticism, not alone at the hands of Englishmen, but even at those of Irishmen, and they have been informed from time to time that the value of their degrees is diminishing. It is remarkable then to see that its graduates obtain eight out of a total of forty commissions. We must not overlook the fact that the first place in the examination has been obtained by a pupil of Queen's College, Belfast, and a graduate of the Royal University—Mr. G. H. Stephenson.

An Irregular Election.

A CURIOUS situation arose lately in connection with the election of an honorary surgeon to the Rotherham Hospital. It seems that two honorary surgeons, Dr. Reid and Dr. Knight, retired and offered themselves for re-election. Dr. Reid was re-elected, but when the second name was submitted a member of the Weekly Board suggested that of Dr. Anderson, who was eventually chosen. Now, it appears, that Dr. Anderson had made no application for the post, and that the use of his name was unauthorised, and, moreover, as the meeting at which the election took place was not a general or special meeting, and that being neither it was not competent for a surgeon to be elected. Dr. Anderson consequently tendered his resignation, and the Weekly Board accepted it. The proceedings gave rise to a great deal of local feeling, and a strong meeting of the Governors was held last Saturday week, at which the Weekly Board were censured for their behaviour. Dr. Anderson's conduct seems to have been perfectly correct throughout, and he deserves sympathy for the invidious position in which he was placed.

Mismanagement Charges.

SERIOUS charges of mismanagement of their infirmary have been made against the Salford Board of Guardians. An ex-attendant is said to have asserted that there was a shortage of food, surgical dressings, and clothing; that the staff was insufficient, and that the inmates were unsatisfactorily treated. A great deal of natural indignation has been displayed in the Borough, and an inquiry by the Local Government Board is suggested by the Guardians. Knowing how badly many infirmaries are managed, we should be glad to see drastic action taken against some of the offenders, but, on the other hand, ex-attendants are not always the best witnesses. At any rate, this case calls loudly for the attention of the Local Government Board.

M.B.B.A. (Ambulance!)

THE assumption of the letters M.B.B.A. by a St. John ambulance official, meaning thereby that he is a member of the British Brigade Ambulance, or some such exquisitely tortured reading, was recently noted in these columns. We had imagined that this act of bad taste was attributable to some silly lad, puffed up by the fact that he had passed a real, live examination and obtained a badge. It seemed incredible that a medical man could have deliberately assumed such a misleading gimcrack title. Yet the letter of a Bradford correspondent, himself a member of the medical profession, apparently leaves no doubt in the matter. If so gross a breach of manners has been committed, the local medical men have the vindication of the honour of their cloth in their own hands. It is not for us to indicate the steps that should be taken, but we are strongly of opinion that something should forthwith be done in the matter.

Joint Counties Asylum Censured.

THE visitors of the Joint Counties Asylum at Carmarthen are under a heavy responsibility. Last year after their visit to the asylum, the Lunacy Commissioners reported that there was no proper system for disposal of sewage, alternate exits were not provided, and that owing to defective laundry accommodation, clothes were washed and dried in the wards.

This year the Commissioners found no steps had been taken to remedy these evils. "This condition of things," wrote the Commissioners, "is not creditable to the authorities to whom is entrusted the duty of providing for the care and welfare of the insane of the counties in the union." We should think not, and it is even less creditable when it is due as in this case it appears to be due, to the mutual jealousies and petty differences between the three authorities concerned. Surely the danger to the unfortunate lunatics' health might first be removed, and the quarrels as to who should pay for what be settled afterwards.

LEADING ARTICLE.

THE PASSING OF THE QUACK.

FOR the last quarter of a century at least, the policy of THE MEDICAL PRESS AND CIRCULAR has been directed ceaselessly against quacks and charlatans. Of late, in season and out of season we have conducted a campaign against irregular medical practice and quack medicines so continuously that the doubt has at times arisen in our minds whether the subject might not become a little wearisome to our readers. The matter is one of no less vital importance to the public than it is to the medical profession. Who can estimate, even remotely, the appalling amount of damage to the national health that is effected by the enormous traffic in patent medicines that claim to cure every ill that flesh is heir to? In view of the admitted incurability of many maladies and of the hopelessness of many more in late stages, the public advertisement of claims to cure by given medicines or by specific treatment amounts to a fraud. Nothing is more certain than that the prosecution both of quacks and of nostrum vendors under such circumstances must be followed by conviction and punishment. The exact legal offence thus committed is obtaining money under false pretences, always a serious matter in the eye of British law. The Medical Acts define stringently enough what is the legal status and qualification of a medical man, and when an outsider trespasses in his field and claims to perform medical acts without a proper professional training, the obvious presumption is that he is a fraudulent scoundrel. The wonder is that with these facts staring us in the face, any persons can be found having the assurance to advertise publicly that they are prepared to cure blindness, defects of vision, rheumatism, locomotor ataxy, cancer, neurasthenia, and, in a word, the whole range of maladies known to man! The explanation, however, is, perhaps, not far to seek. The police of the United Kingdom, efficient as they are in keeping order in the streets and in the protection of the property of householders, are, nevertheless, dilatory in the detection of fraud. The public prosecutor's office is, indeed, for the most part a dead letter, and when it comes to the question of prosecuting a bone-setter or other notorious quack, or the vendor of a cure for Bright's disease or cancer, the highly-paid legal gentleman who holds that post is content to twiddle his thumbs. In the rare instances where the police have prosecuted, conviction has almost invariably followed. The week before last, a particularly offensive rascal was laid by the heels at the Stafford Assizes, in the person of "Professor" Richard. In a comparatively short space of time he netted huge sums of money by claiming to cure blindness and many other serious afflictions. Had the police the courage to follow up the imprisonment of this scoundrel by prosecuting the local newspapers who inserted his lying advertisements, for conspiracy to defraud, the whole of the nefarious quack traffic of the United Kingdom would have received practically a death-blow. From the moment that newspaper proprietors refuse to publish the fraudulent advertisements of quacks and quack medicines, the days of both will be numbered. The police have now shown that it is possible to clap a bogus electrical practitioner into prison; what is possible at Stafford can be done all over the kingdom, if only they could be induced to do their duty. "Professor" Richard is a man whose life is said to have consisted of a succession of convictions for criminal acts, and of sentences of imprisonment. An account of his career, given in the *Midland Evening News* for July 27th, shows him to have been engaged in fraud, criminal assault, bigamy, and the heartless deception of women for nearly forty years. The "medical electricity" business was only one of his ways of duping his fellow creatures and extorting money from the public. Yet, though his antecedents must surely have been known to the police, this despicable creature was allowed to travel all over England and swindle the blind and maimed who came to him for treatment. The only creditable fact in connection with the business is that he has been caught at last, and we hope sincerely that his conviction will put heart into the doubting Thomases in command of the public prosecutions. The case is perfectly clear, and the evidence ready to hand. The man who obtains money from people by the pretence that he can cure incurable diseases is amenable to prosecution. Would that "Professor" Richard might light such a candle in England as to consume the whole of his miserable brethren who, naked and unashamed, swindle the sick and suffering in the light of day!

NOTES ON CURRENT TOPICS.

The Choice of a Holiday.

THE summer holiday is usually believed to be a season for recuperation and for renovation; a time when the jaded tissues are able to cast off effete products of over-activity, and to lay in a store of energy for the coming months. If the holiday is to be this, and not a mere new-sensation hunting performance, the choice of the place in which it is to be passed is of great importance. To go to a seaside town or a mountainous district simply because a friend has gone thither and liked it, is not to plan one's holiday scientifically; which

is another way of saying that for a holiday to do one good, the selection of the place where it is to be passed must be determined by the necessities and conditions of the individual. To many delicate women the strong breezes and bracing air of the East Coast cause exhaustion and prostration, while, again, the relaxing atmosphere of some of our sheltered resorts in the South sends the young and vigorous home but little the better for the trip. Especially needful is the exercise of care in advising old people as to their change. To send elderly and overworked men to the high altitudes is to cause them some not inconsiderable danger of apoplexy, and if they are asthmatical or subject to chronic bronchitis, the rarefied air of high mountains may cause ruinous damage to lungs and heart. Climatology as an exact science is yet in its infancy, but it is sufficiently advanced for a well-educated medical man to be able to advise wisely on the choice of a holiday resort and people generally would do well to consult their professional attendant before booking rooms a month or six weeks ahead.

The Nation's Neglect of Science.

Following the example of several of his predecessors in recent years, Professor Ray Lankester in his address at the opening meeting of the British Association on Wednesday last devoted much attention to the national neglect of science. During the last thirty-five years a good deal has been done at our great universities towards recognition of the importance of science, but much is needed before we can be placed on a level with the Germans, our great and chief competitors in the race of national life. We shall surely be beaten in this race unless we wake up and put forth under wise guidance all our powers. The Germans have now a population of nearly 62,000,000 at home against our total of 55,000,000 of European blood in the whole Empire. The greater population equally endowed intellectually and better educated will surely in the end beat the one that is smaller and less well equipped. The Germans have the enormous advantage of a virtually autocratic direction in all the greater matters of government. The central authority secures the best advice and concerts measures, and these are carried out by a thoroughly trained, experienced, and faithful bureaucracy. The people being throughout sufficiently well educated are able to recognise the wisdom and expediency of government proposals, and however impatient of, or opposed to control in other directions, the Germans welcome every ordinance which promises to add to the people's efficiency. The problem with us now seems how to imbue our democracy with a higher spirit capable of adopting lofty ideals. Our people need to be taught what is meant by science—even this they at present do not understand—and then they need to be made to comprehend what is meant by scientific research. It is difficult to make the people understand the utility of the pursuit of pure science or to recognise the value of those who labour at it. They cannot comprehend the object of work devoted to accumulation of facts which seem to them to have no relation to any utilitarian purpose. They need to be shown that all great, practical advances in arts and manufactures have been always based upon discoveries made with the sole aim of investigating the phenomena and increasing our knowledge of nature and without any dominant thought about any useful purpose to which the new facts might be made to contribute.

Canadian Medical Journal.

In anticipation of the visit of the British Medical Association, the *Canadian Journal of Medicine and Surgery* has published a special number which does equal credit to the enterprise of its editor and the resources of medical journalism in the Colony. It is beautifully printed on a specially-coated paper and contains no less than forty pages of half-tone reproductions of the medical institutions of Toronto, the University buildings, glimpses of Canadian scenery, and portraits of well-known British and Canadian physicians and surgeons. We confess to a feeling of envy as we gaze at some of the hospital and university buildings and compare them mentally with our own. Whatever our hospitals may have to recommend them in the way of tradition and association it is impossible not to turn with something like a sigh towards such handsome buildings as the Toronto General Hospital and Dr. Meyers' Hospital for Nervous Diseases and wonder whether our own sick would not do better in these noble institutions with their beautiful surroundings. One picture that especially impresses itself on our mind is that of the summer quarters of the Hospital for Sick Children, Hanlan's Point, Toronto. There we see a charmingly inviting building surrounded by trees on the edge of a lake, on which latter the nurses are rowing the children about. The new Medical Buildings, Queen's Park, are very handsome; they are modern in the sense of embodying all the requirements of light and fresh air, yet there is a suggestion of an Eastern mosque about them which lends a touch of romance to a structure which over here would probably have consisted of four walls and a roof. We are introduced, also, to some of the public buildings of Toronto, which show the same regard for beauty and utility, and we close the number with the feeling that if our race is able thus to perpetuate all that is good in the mother-country and to recast it in new surroundings with such admirable results, the future of the Empire is in safe hands.

Sanitary Leather.

A noticeable feature of the recent Congress of the Sanitary Institute at Bristol was the amount of interest it occasioned among newspaper readers; that is, if one may judge by the amount of space devoted to the proceedings of the

Congress by the daily press. It is therefore, all the more necessary that the papers read at such meetings should be kept at a high level and should give no opening for the pen of the scoffer. This remark is prompted by the fact that a certain paper—doubtless an admirable one in itself—dealing with the adulteration of leather, has been made the subject of jesting comment by several journals. To argue that the adulteration of leather with glucose or Epsom salts had no bearing on the public health would be to misapprehend the full meaning of the term "hygiene," but surely a paper on the subject would be more acceptable at a gathering of manufacturers or a meeting of Chambers of Commerce than at a Sanitary Congress. Hygiene comprehends everything bearing on health, and as no circumstance or condition to be found in the universe has not some direct or remote bearing on health, hygiene and omniscience come to be very closely related. In fact, we are reminded of a remark once made by Sir Michael Foster, that if some artificial bounds were not set to the scope of anatomy as taught at Cambridge, it would soon be found that the religions of the world formed but a small part of the knowledge required of medical students in their second M.B. There are surely sufficient important matters more closely related to public health that might be discussed in a section of physics, chemistry, and biology than how far it is safe to walk in cheap boots, and what proportion of their weight these articles lose if the wearer steps into a puddle.

Herbalist Conference.

IT may come as news to many of our readers to learn that the people who call themselves "Herbalists" wish to be taken very seriously. They have just held a conference at Nottingham with the object of organising a college or "Physio-medical University," for the United Kingdom. Two American "herbalists" of renown in their own country came over to tell their British brethren how the great heart of the American continent beats in sympathy with the aspirations of their unrecognised brethren in the British Isles. It seems that "herbalism" has secured a position of such dignity in the States as not only to possess physio-medical colleges but even professors, and the National Association of Medical Herbalists of Great Britain listened with bated breath and watering mouth to the stories of the good times enjoyed in America as told by Professor Thurston, of Indiana, U.S.A., and Dr. J. W. Stockey, of Columbus, Ohio. Mr. Marlow, who welcomed the delegates to Nottingham, gave an address, which, for pure "cheek," would, we think, take a lot of beating. He told his audience that "the herbalists' field was the world, and that while claiming the right to use its remedies, they allowed the same right to others. The system adopted by the Association had done more to revolutionise the medical world than any other. *He asked them to strive to keep the medical profession upright and noble.*" We have taken the liberty of putting the last sentence in italics, for, coming as it does from a member of a body of men whose principal function seems to be to sell "worm-powders" to the poor, it strikes us as reaching a height of impertinence that we have seldom seen attained before. The conference debated the subject of promoting a Bill in Parliament to legalise their calling, and finally decided to petition the Privy Council for a charter of incorporation. We fancy that there is little chance of the lords of that august body entertaining any such grotesque proposal.

Inspection of Food.

IN view of the impossibility of safeguarding the purity of food under the present laws, it would seem almost better that these unworkable Acts should be repealed. Under existing conditions, a great part of the public are the victims of misplaced confidence. They imagine that laws once added to the statute book are somehow automatically enforced, and they do not understand that it entirely depends upon the activity and vigilance of local governing bodies as to whether adulteration shall be checked or any supervision whatever exercised to ensure the wholesomeness of the meat, fish, and milk, purveyed in their district. In many places, especially where a certain class of tradesmen dominate the authority, food Acts are either completely neglected or so partially worked as merely to give a false sense of security. It will surprise many readers to learn that even yet there has been no proper arrangement made for the inspection of food entering London, or for public slaughter-houses where control over the meat supply can be exercised.

National League of Physical Education.

A SUCCESSFUL meeting of the National League of Physical Education was recently held at Sir Weetman Pearson's house. The Lord Chief Justice, President of the League, was in the chair, and he was supported by the Bishop of Ripon, Mr. Birrell, Professor Howard Marsh and others. Lord Alverstone spoke of the progress the League was making and earnestly implored his audience not only to devote themselves to the task of improving as far as possible the breed of the English race, but to interest all whom they could influence in this great national question. The Bishop of Ripon and the other speakers all congratulated the Minister for Education on the concession he had made to professional opinion in offering to make medical inspection compulsory in elementary schools, and Mr. Birrell himself confessed he was astonished at the unanimity displayed in the House when the matter was before it. Professor Howard Marsh in warmly supporting all that had been said in favour of medical inspection, allowed himself to go so far as to say that in about ten years we might expect to see infectious diseases banished from the land. For ourselves, we cannot but regret such sweeping prognostications. All

medical men hope that efficient medical inspection may considerably reduce the number of cases of infectious disease among school children, but it is rash in the extreme to expect such cases to disappear altogether. Similar statements have been made in the past, notably at the introduction of isolation hospitals, and they have always been falsified in the event. The only safe rule with regard to prognosis is not to prophesy till you know.

Boric Acid in Food.

The physiological action of boracic acid upon the human body has of late years assumed an important place in public health administration. It has been found as a preservative in milk, cream, and a long array of foodstuffs, especially in hermetically-sealed preparations. Although the precise action of the drug in question has perhaps not been quite adequately ascertained, there can be little doubt that the decision to condemn its presence as an adulterant is upon the whole a wise one. So long ago as 1888, Mr. A. H. Marsh published an account of a case in which boric acid crystals were found in the urine of a patient who had been taking 80 grains of boric acid daily for three days. On evaporation, crystals were found, and on adding spirit to the residue a characteristic green flame was obtained by ignition. The urine was kept in an uncorked bottle for three weeks, and at the end of that time it contained no organisms and was free from disagreeable odour. The cystitis from which the patient was suffering underwent considerable improvement. From various points of view this case is well worth recalling. The general trend of medical opinion nowadays is in favour of the harmfulness of boracic acid. Among children certain deaths have been definitely attributed to its presence as a preservative in cream.

Higher Education in Ireland.

In view of the forthcoming meetings of the Commission appointed to inquire into the affairs of Trinity College, Dublin, and Dublin University, the subject of higher education in Ireland has again come into prominence. Three important documents have appeared in the daily press during the past week. The first is a copy of a correspondence between Archbishop Walshe and Mr. George Fottrell, in which the latter asks whether the Roman Catholic Hierarchy would approve of a scheme whereby, provided it granted the necessary concessions, Trinity College should become a national college acceptable to Roman Catholics. The second document consisted of a statement by certain Fellows and Professors of Trinity College, submitting and approving of the scheme which had been mentioned by Mr. Fottrell in his letter to the Archbishop. The third document consists of a statement of the Episcopal Standing committee of the Roman Catholic Church, and in it the latter body "feels that it is safe in stating that the Catholics of Ireland would be prepared to accept any of the following solutions:—(1) A University for Catholics; (2) a new college in the University of Dublin; (3) a new College in the Royal University; but that on no account would they accept any scheme of Mixed Education in Trinity College, Dublin." We cannot here enter into the merits and demerits of the scheme proposed by certain Fellows and Professors and condemned by the Catholic Hierarchy. It will be discussed to the fullest extent before the Commission. As one who desires that the verdict of the Commission may be uninfluenced by the rancour engendered by diverse politics and religions, we venture to express the hope that, whatever solution is reached, it will be one which will place higher education in Ireland outside the control and influence of clerical authority of any denomination, and equally outside political strife. Further that it will be one which, so far from setting up two rival educational bodies in a land already sufficiently divided, will bring the youth of Ireland together during the most adaptable periods of their lives. Such a settlement of the educational question will undoubtedly be opposed by the professional politician, but we cannot believe that it will not commend itself to conscientious and far-seeing men of every class.

PERSONAL.

Dr. R. C. Brown, of Preston, has given £150 per annum for two years for a pathological scholarship in connection with the investigations being carried out by the committee of rheumatoid arthritis and allied diseases at Cambridge University.

At Liverpool, on July 29th, Superintendent Stowell, on behalf of the officers and constables of F Division presented to Dr. A. F. Walker, police surgeon, a barometer suitably inscribed and a dozen silver teaspoons for Mrs. Walker on the occasion of their marriage.

Dr. T. A. Starkey has just had a distinguished honour conferred upon him, that of being the first scientist of the American continent to be elected to a fellowship of the Royal Sanitary Institute. Dr. Starkey is the head of the Department of Hygiene of the McGill University.

Five hundred English medical men are visiting Canada for the British Medical Association meeting. They will meet there no less than 1,500 Canadian delegates.

Amongst British physicians who will make the journey are Sir William Broadbent, Sir Thomas Barlow, Professor Osler, and Sir James Barr.

Sir Hector Cameron and Sir Victor Horsley will be among the surgeons, and the physiological representatives will include Professor Halliburton and Professor Sherrington.

Mr. Walter Emden's Scholarship of £100 for the best original work produced in the laboratories of the Middlesex Hospital has this year been awarded to Dr. Victor Bonney.

It is reported that at the meeting of the British Medical Association at Exeter next year, Dr. Davy will be President of the Association.

A CLINICAL LECTURE
ON THE
THE CONNECTION BETWEEN TUBERCULOSIS AND SYPHILIS.

By JONATHAN HUTCHINSON, LL.D.Oxon., Hon.M.D.Dub., F.R.C.S., F.R.S.,
Consulting Surgeon to the London Hospital, the Hospital for Diseases of the Skin and Royal London Ophthalmic Hospital.

GENTLEMEN,—Our subject to-day is "The Connection between Tuberculosis and Syphilis," and I think it would be convenient if we endeavoured to establish a few general principles, rather than go into detail on any one point. You can easily interpret the principles and apply them.

The manifestations of syphilis are very variable, although the majority of cases are tolerably alike. If we were told that a man had suffered from syphilis, we should know that he had had chancre and an eruption, and we should be able to tell the character of the eruption. That is in reference to the general run of cases. But there are cases of syphilis which substantially differ from those in which the disease commonly manifests itself. One man, instead of having a papillary eruption, in syphilis, may develop a bullous eruption, or be covered with psoriasis, and so on. In the later stages of the disease a patient may develop a lupoid eruption: instead of the early eruption fading away satisfactorily under ordinary treatment, he shows a tendency to have a sore on his skin, which persists for a long time, resembling the ordinary form of tubercular eruption.

What is the law by which we shall seek to interpret these remarkable differences? I think we shall be willing to admit that the virus, in all probability, is always the same. In recent years we have got a good deal of evidence as to what that virus is, and we believe we have reason to infer that there must be, in such a specific and peculiar disease as syphilis, a specific virus to explain the phenomena present in a patient who is suffering from it. Some living virus is introduced into the blood at the time of contagion, and is multiplied in the blood, and produces the various features that characterise the disease. That inference has been recently confirmed very remarkably by the discovery of a spirochæte, a protozoan, not a vegetable thing, but more like animal life, which, if introduced into the blood, gives rise to syphilitic phenomena. In past times some authorities held that the different forms of eruption, in syphilis, had to do with different forms of poison which had been introduced into the system. Without going far into argument upon that question, the evidence that we have would go to show that the virus of syphilis is one and the same in all cases. We find, in populations in which syphilis is existent, that single individuals manifest one peculiarity of eruption, and other single individuals manifest another. We cannot believe that, in syphilis, in England, there can be any remarkable difference in the virus; if there were, we should have a little epidemic of one kind and another, in connection with the disease.

To account for the differences which are sometimes manifested, I think we may reasonably point to a well acknowledged fact, namely, that individual men do not exactly correspond in all their proclivities. It is individual peculiarity in the recipient of the poison—not in the poison—which accounts for all the differences of syphilis. Then again, there may be differences manifested in the disease which are due not so much to the virus itself, as to the specific remedy employed. One patient, for instance, cannot take mercury in large quantities, and another can; one man may be able to take sufficient mercury to kill the spirochæte, whereas another cannot take enough to destroy the parasite. And so the remedies employed will often give mixed results. But, quite apart from the influence or non-influence of treatment, we may assume that the peculiarities in individuals who contract syphilis account for the peculiarities in its manifestations.

In reference to peculiarities in individuals, I may say that we must believe that many persons have only a quite latent, quite concealed, but still a very distinct proclivity to certain diseases. Take, for instance, the eruption of psoriasis, common psoriasis, which occurs in persons of very fair health. We are not aware of any special influence which produces it. Patients who get psoriasis have some proclivity towards it which we cannot detect. There may be a peculiarity in a person which does not show itself at once, but yet there is in the skin a tendency to produce those scales and patches which characterise this particular affection, a tendency which renders him liable to nothing else at all. So that there is an innate tendency to psoriasis. I need not tell anyone that when once the proclivity to psoriasis has shown itself it lasts through the patient's lifetime. You give him arsenic and he gets rid of the eruption, but it comes back again. Pemphigus is a disease met with in persons who are apparently in good health. Suddenly a man becomes covered with bullæ characteristic of pemphigus. So also as regards many other forms of skin disease. The proclivity to papillary gout exists in a very large section of the British population, though, I believe, it is diminishing every year. A great many people are born with a tendency to that form of gout, though the tendency varies in different individuals. Then there is also a proclivity for the skin, when inflamed, to let its papillæ grow, and such a condition in any person makes him liable to lichen or acne, which are both affections of the glands connected with the suppressed hairs on the skin. Or a person with papillary growth may develop warts.

A very peculiar form of syphilis is developed in the Tropics, and occurs occasionally in England, producing a tendency in individuals towards papillary hypertrophy. The syphilitic poison, having been introduced into the blood, causes not only inflammation and eruptions due to congestion and exudation in various parts of the tissues of the skin, but produces actual growth. It is a very peculiar fact indeed. For instance, at the back of the tongue of patients passing through the secondary stage of syphilis, you may frequently see a very definite development of papillary warts. Something in the spirochæte seems to stimulate papillary growth. To this condition of papillary growth which is a common manifestation of syphilis in the Tropics, especially in the West Indies and East Indies, various names have been given. It is sometimes described in books as Framboesial syphilis, and tends, more than other forms, to the development of papillary growth. I do not think it has any definite or special connection with hot countries—typical cases occur in this country as well as in the Tropics—but it reveals a tendency in the individual, which may be a tendency in the family or in the race, to papillomatous growth in syphilis.

I have made these introductory remarks in order to come down to our more definite subject, *the connection between tuberculosis and syphilis*. May we just speculate a little upon what is likely to happen when a person who has the tubercle bacillus in his blood happens to contract syphilis. Will the syphilis run its ordinary course? or will it rouse the tubercle

(a) Lecture delivered at the London Hospital, June 19, 1906.

bacillus to action? or will it leave the tubercle bacillus quite alone? When they meet in the blood, will they stimulate each other towards producing any further kind of result? In the primary stage of syphilis, I think, it is not probable that a phthisical patient will encounter any difference at all; probably he will be very much the same in the early stages. The tubercle bacillus is almost ubiquitous, it is present in nearly everybody, but it is, more or less, kept latent, and there is plenty of evidence to show that it does not develop until some influence is exerted which excites it into action. So that we will not be surprised if a patient, having contracted syphilis, may manifest certain symptoms indicating that he has also tuberculosis, although he has not shown these symptoms before. Here let me introduce the doctrine, which may be familiar to some, of what is called symbiosis, and which signifies *two lives united in one*. In botany you have an illustration of this doctrine in the union of two quite different plants which grow into each other, the one stimulating the other; and when that occurs, it produces a third being called a lichen. It is highly probable that this process of symbiosis goes on in a great number of different forms. Many things live together and produce results quite different. I thinkit is very likely that the tubercle bacillus and the poison of syphilis can in some way unite symbiotically and produce a third condition which is not characteristic of either one of them. There is such a thing as a recurrent chancre. A person, say, has suffered from syphilis four, five, six, or seven years ago, and then the scar left on his penis, where the chancre was, and which has been perfectly quiescent for that time, takes on an induration which is exactly like the original. There is a means, however, of distinguishing it from the original. A primary chancre contracted, for instance, by contagion from a sore, almost always begins by an abrasion of the surface. The scar of an old chancre does not begin on the surface, but under the surface by the development of induration. In primary chancre the induration is secondary to a certain amount of abrasion, and the patient has this peculiar induration lasting perhaps for many months and very difficult to treat, but eventually yielding to treatment. For some years we have been conversant with this class of recurrent induration which I have mentioned. You never see either it or primary induration except in people who are syphilitic. My reason for insisting on this point is in order to mention a recent fact which has come to my own knowledge bearing upon the doctrine that I have already called your attention to, the doctrine of symbiosis, according to which the union of the tubercle bacillus with the poison of syphilis is a possible contingency. A gentleman came to me, whom I had treated some six years before for syphilis. I had known him well for several years. He came to me with a hard, conspicuous induration on the free margin of his prepuce. I thought it was a chancre; only, the patient seemed to be in perfect health. However, knowing how difficult it was to get that sort of growth to disappear, and also being very much interested in the development of our knowledge as regards the presence of the spirochæte in syphilis, we were very anxious to know whether the spirochæte was present. Accordingly, I told him to get the growth cut off. He said, "Yes, have it cut off for microscopical examination"; and so he was circumcised and the whole of the induration was taken away. I sent the prepuce to the Clinical Investigation Department, and it was examined by a very experienced microscopist. I told him that I wanted to know whether the spirochæte was there. To my astonishment I got a report back, stating that the induration was not syphilitic at all, but that it was a very recent infection of tuberculosis. He had found the tubercle bacillus, but could not find the spirochæte at all. When I expressed my astonishment at what he had stated, he said, "If you do not believe it, show the thing to somebody else." I did show it to several persons skilled in microscopical matters, and they also said that it was tubercular. This confirms my theory that in connection with syphilitic scars, conditions which are characteristic of tuberculosis may be produced, and that syphilitic forms of inflammation may be associated with recent tuberculosis.

We come to the next topic, which is, the disease known as lupus. I daresay that most of you are conversant with the appearance of common lupus, which is supposed to be always in connection with tuberculosis. The disease known as lupus is chronic inflammation of the skin, tending to thicken and to the formation of granulomatous tissue. A good deal of soft tissue forms, and there is a tendency to ulceration and a tendency to spread. Lupus is always worst in cold weather, and occurs in delicate patients, and it is clearly infective in the patients themselves, because it travels from part to part.

My next point is that there is, in connection with syphilis, an eruption which is exactly like lupus. This eruption occurs, not in the secondary, but in the tertiary stage, in the form of gumma of the skin. It is a granulomatous formation in the skin, in connection with syphilis, which spreads like the ordinary forms of tubercular lupus. I use the term *tubercular* when the lupus forms in association with the tubercle bacillus. When, on the other hand the lupoid skin, though it may simulate tuberculosis, is associated only with syphilis, I make use of the term *syphilitic*. A skilful dermatologist will tell you whether a given case of lupus is syphilitic or tubercular, but very often, to the ordinary observer, syphilis is exactly like tuberculosis. There are, however, certain differences by which you can generally diagnose the one form of lupus from the other. In connection with tubercular lupus there is a sort of brown, semi-transparent thickening of the skin, exactly like brown jelly. That often shows considerable thickness. You do not get such thick masses of it in the forms of syphilitic ulceration which simulate tubercular lupus. In tubercular lupus the general spreading is slow; in the syphilitic form it is more rapid, and there is also more tendency to inflammation and the formation of crusts.

As regards this disease which we call syphilitic lupus—a name to which many of my friends would strongly object—my suggestion is that the disease is really a combination of two things occurring in a patient. It is the presence of the tubercle bacillus which gives the tendency to the syphilis to spread. Why should only one patient in a hundred of those suffering from syphilis have got any syphilitic lupoid disease? This disease would be far more common than it is, if it were the direct result of syphilis. My own impression is that syphilitic patients who have the tubercle bacillus suffer more frequently from tubercular lupus.

One means commonly adopted in the treatment of syphilis is to give iodide of potassium and mercury. It is held that mercury kills not only the spirochæte, but the tubercle bacillus. A very skilful physician, in olden times, used to give small doses of mercury to cure phthisis and all tubercular affections. The same treatment is beneficial in syphilis, and if tonics be combined it may be useful in tuberculosis and lupus. But I think the most efficient plan of treatment for syphilitic lupus and tubercular lupus is to entirely destroy the tissue which is affected, using either the actual cautery or chemical cauterization.

There are a great many remarkable coincidences of similarity between these two forms of disease, and in cases of syphilitic lupus there is often a history of tuberculosis. I constantly ask my patients who have forms of syphilitic lupus whether there is a history of tuberculosis, either threatened or actual, in the family. I remember having a patient, a man, very much worn out in health, and a typical example of syphilitic lupus in its severe form. I said to him, "What is the history of your relatives? What have they died of? Have you any brothers and sisters?" "No, all have died of consumption. He himself had been threatened by that disease, and his statement illustrates a well-known fact, that a great many of

those who suffer from syphilitic lupus have a history of tuberculosis either in themselves or in their families.

Are there any other forms of disease in which the tubercle bacillus unites with the syphilitic virus? Although I do not find that patients with syphilis come to me because they suspect themselves as being phthisical, nevertheless I have seen a great number of syphilitic patients suffering from phthisis. It is extremely frequent for syphilis to pass into phthisis. I remember one marked case in which a student who had syphilis became phthisical and died. That is almost the only case of the kind that has fixed itself on my memory.

Syphilitic gumma is also a disease with which tubercle may be associated, though very rarely does that happen. I am trusting to the testimony of eminent pathologists who have collected a large amount of evidence on the subject. A very distinguished pathologist in Guy's Hospital informed me that very rarely indeed had he found tuberculosis in association with syphilitic gumma.

Gland disease is often found quite definitely in connection with syphilis. I remember one case in which a woman had been under my care for some time with gland abscesses in her neck. The case occurred in those days when we did not think of excising diseased glands. I did not think the patient was syphilitic, but that she was tuberculous. Finally she brought me her latest child, and I traced evidence of this child being syphilitic. I afterwards saw two of the other children, who confirmed the fact of the existence of syphilis in that woman's children. I had treated her for a long time as being a tuberculous case, but in her case there was a tendency to suppuration, such as occurs in syphilis.

There is a very interesting condition of perforation of the septum of the nose which may occur in syphilis. But it has now been ascertained as an established fact that there is a tubercular affection of the septum of the nose which exactly simulates syphilis, but is not connected with syphilis at all.

I have been dealing hitherto with acquired syphilis. I ought also to have said something as regards hereditary syphilis. I do not know of any very definite examples of cases in which patients with a tuberculous tendency have suffered from hereditary syphilis. But it is very possible that patients who inherit a tendency to tuberculosis may inherit at the same time the poison of syphilis, and in these cases mixed results may ensue, as, for instance, syphilitic scrofula. In olden days all forms of scrofula were considered to be syphilitic, but in the present day we believe that a great deal of what is called scrofula is chronic gland disease, and has no taint of syphilis at all. Though the two things may resemble each other very closely they are not really related, and certainly one may occur without the other. But I have known cases in which the conditions usually termed struma were very probably the results of syphilis.

The principles, therefore, which I lay down in connection with our subject are these:—Tendencies to disease are very often latent; these tendencies may be modified by the introduction of syphilitic poison; and this poison may subsequently exert its influence not quite definitely in the same manner that it would have done if there had been no previous hereditary poclivity, but when found in association with this proclivity, it may give mixed results. I believe that these principles interpret a great many conditions, in connection with syphilis, which it would otherwise be difficult to diagnose.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week's issue will be by Jonathan Hutchinson, LL.D., Oxon. and Cantab., Hon. M.D. Dub., F.R.C.S. Eng., F.R.S, Consulting Surgeon to the London Hospital, the Hospital for Diseases of the Skin and the Royal London Ophthalmic Hospital on "Diseases of the Skin Caused by Insects," delivered at the London Hospital, July 3rd, 1906.*

ORIGINAL PAPERS.

THE HÆMOPTYSIS OF TUBERCULOUS SUBJECTS.

By G. LEMOINE, M.D.

Of the Faculty of Medicine of Paris.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

HÆMOPTYSIS due to pulmonary tuberculosis is by far the commonest form met with in practice, and if only on account of its importance, deserves to be dealt with separately and discussed in its different aspects according to the stage of the disease at which it makes its appearance. We recognise, of course, that hæmoptysismay be dependent on other causes than tuberculosis; but these non-tuberculous cases are extremely rare, so rare indeed, and these few so open to suspicion, that, speaking generally, it may be asserted that nearly all cases of hæmoptysis, however scanty or ephemeral, are more or less associated with tuberculosis.

Laennec, Trousseau and other observers, it is true, asserted that at least half the cases of hæmoptysis were due to some other cause than tuberculosis; but this opinion was based on the assumption that, as many of the patients did not subsequently develop tuberculosis, they were therefore not tuberculous, whereas we now know that it is quite possible to be tuberculous without becoming phthisical.

From a clinical point of view the cases must be subdivided, not only in regard to prognosis, but also in respect of treatment. We shall therefore divide them into three groups. (1) The premonitory hæmoptysis that appears before the local signs of pulmonary tuberculosis have become manifest. (2) Hæmoptysis of the congestive period, occurring at a stage when the signs of pulmonary tuberculosis can be detected. (3) Terminal hæmoptysis met with during the period of ulceration and the formation of cavities.

PREMONITORY HÆMOPTYSIS.—I will read you the notes of a very typical instance of this form of hæmoptysis: A young man, aged 18 strong, robust and addicted to athletic pursuits, was suddenly seized with hæmoptysis one evening about two hours after dinner. It came on suddenly, without obvious cause; he began to cough and then expectorated blood-stained sputum in considerable quantity; in fact during the night he expectorated a small tumblerful. On the following day the hæmorrhage had ceased but forty-eight hours later the cough returned, and again he spat blood, after which the attack came to an end. The attack ran its course in three days without fever and without any obvious lesion. During the attack stethoscopic examination revealed some dulness of the respiratory murmur and roughness on inspiration. The chest was resonant, and no mucous or sub-crepitant râles could be heard. Even these trifling symptoms had disappeared at the end of the week.

We have to ask ourselves whether this apparently robust young man was, in reality, in good health when attacked by hæmoptysis. We elicited from his family that for several weeks preceding the attack he had been indulging to the full in all sorts of athletic pursuits, dining out almost every evening, going to dances, in short he had been leading a very active existence. For some days previously, however, he had not

been feeling quite well, complaining of lassitude and general malaise, with loss of appetite, in spite of which he had been leading a more fatiguing life than ever.

Everything having returned to normal our patient resumed his previous mode of life and continued to remain in excellent health, in fact he did his military service two years later and was certified as robust. Two months after returning to his regiment he had a fresh attack of hæmoptysis which, this time, lasted a fortnight, with an evening temperature between 99° and 101°F. The hæmoptysis ceased, but on auscultation a congested area undergoing softening was discovered on the right side of the chest, and at present he is under treatment in a southern town with one apex breaking down, and the disease is progressing rapidly.

Here is another example, that of a young woman in whom the hæmoptysis was thought to be "vicarious." She was twenty-two years of age, and had for some time been feeling tired and languid. She spat small quantities of blood from time to time at her menstrual periods. As she coughed her lungs were examined, but nothing was discovered beyond a little respiratory roughness. Two days later nothing whatever was audible, there was no cough, no blood spitting. It was thought that the blood might be merely complementary to deficient menstrual flow, what is known, in fact, as supplementary hæmoptysis. By supplementary we mean a discharge of blood that has been deviated from its normal course and escapes *via* the lungs. In the great majority of instances vicarious menstruation takes place *via* the lungs, and most of us have, at one time or another, met with instances of the kind. I remember a case at La Salpetrière, a woman who for forty-two years had sharp bleeding from the lungs at her menstrual periods consequent upon sudden arrest of the menses; also the case of a woman sixty years of age who had never menstruated *per vias naturales*. How can we explain this catamenial hæmoptysis? In all probability the suppression of the menses is not the cause but the effect of a pre-existing tuberculosis, the menstrual hæmoptysis being the consequence of a monthly congestion in and around the tubercles. Moreover, women who exhibit this vicarious menstruation may, and often do, become tuberculous. What are we to conclude from all this? I think we must admit that there exists such a thing as vicarious menstruation, but we must nevertheless be on our guard when we have to deal with girls who menstruate *via* the lungs. Such menstruation ought only to be classed as vicarious when after careful examinations repeated at long intervals we have convinced ourselves that the lungs are intact.

But how can we distinguish between this catamenial hæmoptysis and essential symptomatic hæmoptysis? Well, menstrual hæmoptysis is copious—a quart or more of blood each month, while essential hæmoptysis is a recurrent phenomenon, we have to-day a few blood-streaked expectorations, to-morrow nothing, the quiescent period may last for hours or even days, and then the blood-spitting recurs. The first variety then comprises a sudden outrush of blood and nothing between the periods, no blood-stained expectoration, and the general health is unaffected. This catamenial hæmoptysis is most frequently seen in hysterical, neuropathic and hypochondriacal subjects. To come back to my patient, two years later she had a fresh attack and this inaugurated unquestionable tuberculosis.

Here is a third observation of the kind. This was an arthritic subject who, on making a violent effort, spat blood. On auscultation one apex was found to be consolidated. Things returned to normal a few days later. Here we have to ask ourselves whether the hæmoptysis was due to the arthritism or whether there was a latent tuberculous lesion.

The arthritic subject, you must remember, manifests congestive tendencies. This congestive tendency may manifest itself anywhere, and the hæmoptysis may, as a matter of fact, be due to arthritic congestion localised in the lung. We recognise arthritic hæmoptysis by its sudden onset, its rapid disappearance, its relationship to barometric variations, and by the fact that it usually supervenes at night. Dr. Huchard, who has fully described the arthritic variety of hæmoptysis, only relates one case, and it is the only one in which an autopsy had been made. The subject was not tuberculous, it is true, but, on the other hand, the evidence of arthritism was not very clear either—in short, hæmoptysis of arthritic origin does not so far repose on any very conclusive basis of fact.

I have described three varieties of unexpected hæmoptysis occurring in apparently healthy subjects. The prognosis is benign in the premonitory cases if the patient is intelligent, is willing to do what he is told and is attended by a practitioner who knows how to deal with such a case.

And now as to treatment. The practitioner will have to choose from the many medications recommended in the treatment of hæmoptysis those whose action is least uncertain and most rapid. Rest in bed is the first step, with absolute repose, even talking to be forbidden. Internally there is nothing better than ergotine, which acts by constricting the vessels. This may be given either by the mouth or hypodermically. Mustard plasters or poultices may be applied night and morning to the affected side, and an aloes pill (gr. 2 or 3) should be given daily. Hot foot-baths at midday and evening, iced drinks, and so on.

Hæmoptysis at a More Advanced Stage.—Hæmoptysis at this period is easy to diagnose. You find dulness over the apex, vocal fremitus is accentuated and inspiration rough, this settles the question of tuberculosis. Hæmoptysis is always possible in such patients, and this early hæmoptysis is characterised by the following symptoms: a dry cough two or three days before the attack, a tendency to shivering, to sweating, to fever, then, suddenly, in the midst of this discomfort, the cough becomes more troublesome and blood is coughed up, it may be in considerable quantities. If you examine your patient at this juncture, in addition to the stethoscopic signs just enumerated, you will hear sub-crepitant rales indicative of a tolerably severe congestion. The hæmoptysis may last a week or more, and is accompanied by a marked rise of temperature which may last as long as the congestion. This variety of hæmoptysis often causes anxiety by reason of its copiousness and its tendency to recurrence, constituting what is called hæmoptoïc phthisis.

Certain authors who did not appreciate the importance of the signs of incipient tuberculosis, promulgated the odd view that tuberculosis might be the consequence of hæmoptysis, the so-called *phthisis ab hæmoptoë*. To accept such an explanation we should first, says Debove, have to discover, in this hæmoptysis reputed to be the precursor of phthisis, some conceivable cause other than tuberculosis.

Now, thanks to modern researches, we are in a position to assert that hæmoptysis is never anything but the earliest sign of the disease, for in the expectorated blood Hiller has identified the tubercle bacillus, and was thereby led to conclude that the hæmoptysis was the effect and not the cause of the tuberculosis. The treatment of this form of tuberculosis is, in general, the same as that already described, and it is often successful in arresting the hæmorrhage and the tuberculosis, provided the patient can and will adopt suitable measures.

HÆMOPTYSIS OF THE PERIOD OF CAVITY FORMATION.—This form of hæmoptysis is less frequent than that just mentioned. It is, however, more copious and entails greater immediate danger. It takes place at the period of breaking down of the areas of consolidation and the blood is derived from the cavities. The rupture of vessels in these hæmorrhages seems to be the consequence, on the one hand, of the obliteration of a certain number of twigs of the pulmonary artery by interstitial sclerosis developing in the walls of the cavity; on the other hand of a rise of blood pressure in the pulmonary vessels that have remained patent and have become more fragile as the result of inflammatory-degeneration and deprivation of their natural support following upon the destruction of the pulmonary parenchyma.

Hæmoptysis at this period may occur in one of two forms, as red masses mixed with matter or as pure blood. In some instances there is merely a sanguineous exudation from tissues undergoing softening, or the hæmoptysis may come from the neighbouring zone of congestion in which event it may be copious, possibly even immediately fatal.

Hæmoptysis at the period under consideration varies in prognosis according as there is or is not fever. If febrile the disease is gaining ground, and the activity of the micro-organism is intensified. These hæmorrhages are very grave, and indicate the onset of an acute period, which will soon culminate in the destruction of the patient. In the absence of fever the prognosis is favourable, the hæmoptysis being regarded as a local accident without bearing on the general health.

At a still more advanced period patients may have hæmoptysis with each outburst of congestion consequent upon the rupture of vessels in the neighbourhood of the cavities. When hæmoptysis follows rupture of one of these vessels the blood escapes from the mouth in large quantities, three, six, or ten ounces at a time; the patient is seized with fear at the sight of the blood, he becomes pallid, there is tremor, acceleration of the pulse and then a final syncope closes the scene.

The treatment of these cases varies according as there is or is not associated fever. Febrile hæmoptysis must be dealt with on the same lines as the premonitory hæmoptysis. The patient should be placed in a cool and well-ventilated room, in a semi-reclining position, the head resting on a horse-hair pillow. He must avoid efforts of every kind, should, as far as possible, refrain from coughing and remain perfectly quiet and silent. To begin with he must only take iced drinks. Counter-irritation by dry cupping and mustard plasters, very hot foot-baths twice daily. Ergotine should be injected hypodermically at once (Tanret's ergotinine 1-100th to 1-50th grain), or injections of adrenaline in doses of 1-100 grain daily. Ergotine and adrenaline only act on vessels provided with a non-striated muscular coat, which is not present in the pulmonary capillaries. We must, therefore, give emetics, such as ipecacuanha and tartar emetic. The active use of emetics, which were popularised by Trosseau, is remarkably hæmostatic.

QUACKERY, OTHERWISE HUMBUG.

ABSTRACT OF GRADUATION ADDRESS AT EDINBURGH UNIVERSITY.

By THOMAS ANNANDALE, F.R.C.S.,

Professor of Surgery in the University of Edinburgh, &c.. &c.

Two theories have been suggested to explain why primitive man first had recourse to internal remedies in the treatment of disease, the one being that it was accident, the other, imitation of the lower animals. Pliny's fabulous account of the origin of vivisection was that the hippopotamus, having become too fat and unwieldly through over-eating, thrust his nose into a sharp-pointed reed, and when he had drawn sufficient blood, he closed the wound with clay. Probably the first special treatment of disease was due to the Egyptians or Chaldeans; from them the Greeks obtained their knowledge, and Cheiron was the first to instruct his countrymen, among them Æsculapius, who is credited with being the originator of medicine as a distinct profession. Between the days of Æsculapius, who flourished in 1200 B.C., and those of Hippocrates, four hundred years later, medicine and myth are inextricably intermingled; the practice of the art seems to have been in the hands of a priesthood, who worshipped in temples devoted to Æsculapius as the god of physic. With the writings of Hippocrates a new era dawned, for they show a marvellous knowledge of injuries and disease, and contain methods of treatment founded on sound principles. As knowledge and civilisation advanced, although improvements in the art of medicine took place, quackery continued rampant. The credulity which the study of quackery discovers, almost approaches monomania or insanity. This credulity is explained by the fact that in all times there have been men and women of strong personalities and unlimited self-assertion who dominate their fellow-creatures and exercise a power for evil as well as good, and it is also explained by the natural tendency of a patient with a chronic illness to seek help from any source. Before dealing with quackery in the present time, some of its exponents in the past might be mentioned. There was Buley, for instance, in the days of Edward VI., who gave roasted rats as remedies to sick children; touching for the king's evil, which attained its height in the reign of Charles II.; the quack oculists of Queen Anne, who suffered from weak eyes, and was treated by Wm. Reade, a tailor, and Roger Grant, the cobbler and Anabaptist

preacher. Mesmer flourished in 1776, and a commission of the French Academy of Science was deputed by the king to investigate his claims. Among noted quacks of the past were Katterfelto, who wandered through the country with a caravan full of black cats, and was finally condemned as a vagabond by the Mayor of Shrewsbury; a Dr. Graham who sold an elixir of life to anyone who would pay him £1,000 for it, and conducted a Temple of Health in which Lady Hamilton, Lord Nelson's goddess, took part in musical performances. Again, there was the fat, ugly, tippling Mrs. Mapp, with her carriage and four, who was esteemed as a bone-setter, and known popularly as "Crazy Sally of Epsom." A very notorious quack was St. John Long, son of an Irish basket-maker, who acquired fame as a healer. His house in Harley Street was flocked to by the rank and fashion of the day, who were treated by inhaling some mixture through a tube. The street was often blocked by his patients' carriages; he was received into the best society; it is said that he made £13,400 in one year. He ended by being tried for manslaughter at the Old Bailey, but escaped with a fine of £250. Faith cures, and cures acting on the imagination, have thus flourished from very early times, and more recently a faith cure, under the name of Christian Science, has sprung up. In this we see history repeating itself. In ancient and more modern days so-called faith cures have been carried out by the aid of ceremonies and incantations, and the erection of temples to aid the imagination. According to what we read and hear, Christian Scientists are following in the same footsteps. If they aid in promoting temperance in alcohol and tobacco they will do good, but if they profess to cure disease by their methods, or to assert that there is no such thing as real pain, then we are justified in calling them quacks. How can quackery be checked? In the first place, the medical profession must not practise quackery themselves, for it is too true that it exists inside as well as outside of the profession. Then it is important to individualise in treatment so as to secure that patients may reap the greatest benefit, while careful and accurate diagnosis and prognosis will help to guard against disappointment. In this country there is no legislation against quackery. The Government receives £300,000 annually from the licences and stamp duties on the sale of patent medicines. Many patent medicines in no way comply with the law requiring that they must be genuine original inventions, and that a complete description of them must be filed at the Patent Office. In both France and Germany there is at present a great deal of agitation in favour of greater stringency in dealing with quackery, and stricter supervision of proprietary remedies. In conclusion, it is important to realise the responsibilities resting on those entering upon the practice of medicine, both in exercising the sympathetic faculty, and in cultivating friendly intercourse with patients of all classes.

The consumptive patients in Lambeth Infirmary have been in the habit of looking out of the windows of that institution overlooking Gilbert-road, but the residents loudly complaining that this habit created fear that contagion would be spread, the guardians have decided to remove the consumptives to other quarters.

SOME REMARKS ON A NEW FORM OF ADMINISTRATION OF FORMALDEHYDE.(a)

By H. W. O. SEIFERT, M.D.,
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The pharmaceutical preparation known as formamint tablets represents the product of a two-fold combination of formaldehyde. They contain, with the addition of sugar and gum arabic, a proportion of ·01 formaldehyde, by weight, in 1 grm. of the total combination. Citric acid is added for purposes of palatability, while a few drops of pepsin-hydrochloric acid ensure the liberation of free formaldehyde during the solution of the tablets in the mouth. The tablets as put on the market are odourless and possess a pleasant refreshing taste.

Experimental investigations made with collections of streptococci, pneumococci, typhus, and diphtheria bacilli demonstrate that a solution of one tablet in 10 c.c. of water destroys their germs in from five to ten minutes. Culture tubes of bouillon, agar, or gelatine, to which this solution was added, proved sterile, so that no growth took place in them, while distinct and characteristic development of the bacilli took place in control tubes.

Experimental research on animals gave similar results.

The investigations of Rosenberg (1) prove beyond the possibility of objection, that formaldehyde is to be found free in the blood after internal administration. Further researches are required in order to determine in how far these formamint tablets are calculated to exert antibacterial and antitoxic actions in the body respectively, in the course of infectious diseases.

Formamint tablets are especially indicated in the treatment of infective diseases of the throat. They act as substitutes for gargles, and disinfect the area of disease locally, while they are also absorbed internally and influence the whole organism in general. The claim of formamint for therapeutic employment rests on its great bactericidal value. This value is of great importance in general practice, because of the various difficulties associated with efficient gargling, not only in regard to children, but also in the case of some adults. I have learnt to attach great significance to the worth of these tablets, because I used them extensively, in cases of follicular tonsilitis, during last winter and spring, and they have answered in excellent manner, more particularly with young children who were unable to gargle. These tablets stood me in very good stead in a case of ulcer of the posterior pharyngeal wall, the patient being three years only and incapable of gargling. There was great pain on swallowing and considerable fœtor emanated from the mouth. I ordered one half-tablet to be taken every two hours, and I found after the lapse of twenty-four hours that the pain on swallowing was greatly relieved, and the fœtor was almost gone. In six days the ulcer was healed.

Further evidence is required before an estimate can be made of the value of the formamint tablets in whooping cough, but I am fully satisfied of their efficacy in various forms of subacute and

(a) Reprinted from the "Pharmakologische und Therapeutische Rundschau." No. 14. 1905.
(b) Rosenberg: Therapie der Gegenwart. 4. 1905.

chronic pharyngitis. The irritability of the pharyngeal mucous membrane is diminished, and the phlegm is loosened.

When required the tablets may be dissolved in warm water of a temperature of 95° F. A solution of one tablet in about six drachms of water forms a disinfectant mouth wash, containing formaldehyde in the proportion of 1 in 20,000. It is stronger than a 5 per cent. solution of carbolic acid or a 1 in 1,000 solution of sublimate, and it is moreover absolutely unirritating.

Robert (*a*) records a case of a striking cure in fœtid bronchitis, under the prolonged use of these tablets.

They are splendidly adapted for use by school children as a prophylactic against infectious disease, especially during the prevalence of an epidemic. I am in the habit of prescribing one tablet for children as soon as they return home from school.

It should be further stated that for the last few months our skin and syphilitic patients who are undergoing mercurial treatment have been given these tablets, both in their ordinary and double strength, in order to avoid stomatitis. The results have been quite satisfactory. When stomatitis from mercury is once established the tablets have no effect.

As a result of my clinical observations I am compelled to state that formamint tablets are a valuable acquisition to our pharmacopœia, more especially in the treatment of infective inflammations of the mucous membranes of the mouth and pharynx.

CONCUSSION OF THE BRAIN (SO-CALLED) AND ITS TREATMENT.*

By W. THELWALL THOMAS, F.R.C.S.,

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SYNOPSIS.—*Peculiarities of the cerebral circulation. Simple concussion is either* (a) *altered equilibrium of fluid pressure in the cranium, or* (b) *shock. Continued unconsciousness denotes cerebral contusion or laceration, and its possible complications—encephalitis, arachnitis, &c. Prognosis: Treatment as for shock. Symptoms often prolonged by the use of ice. Brain contusion or laceration best treated by quietness, rest, sedatives; after-effects by iodides and free nourishment.*

PHYSIOLOGICAL research during the last decade has made it necessary for us to reconsider the question of concussion of the brain.

During life the cranial cavity is almost entirely filled by brain matter and blood, the amount of cerebrospinal fluid being so small as to be a negligible quantity, merely serving to moisten the surface of the brain and form small collections in a few places. If, from any cause, an excess of cerebrospinal fluid is secreted, absorption takes place once its pressure exceeds the cerebral venous pressure—equilibrium being quickly restored by absorption into the cerebral veins.

There is no evidence of the existence of vasomotor nerves or of any vasomotor mechanism in connection with the cerebral vessels, so that the circulation of blood within the cranial cavity passively follows the changes in the general circulation; in other words, the splanchnic vasomotor mechanism controls the cerebral circulation indirectly through the general circulation. Active spasm of the cerebral arteries or arterioles has never yet been demonstrated experimentally, and must be assumed not to exist.*

The ready absorption of cerebrospinal fluid by the veins makes the cerebral venous pressure of far greater moment than the arterial; obstruction to the venous return in heart disease or pulmonary affections readily affects the equilibrium of fluid pressure in the brain, and, as we know, often causes cerebral symptoms.

Gravity will have a marked effect on the cerebral arterial pressure if by any means the splanchnic vasomotor mechanism is in abeyance; thus, in chloroform anæsthesia, or shock, any sudden change of the posture of the patient to anything approaching the vertical, produces cerebral anæmia, and the result can be described as syncope, shock, or concussion. Brain matter in itself is incompressible; it thus follows that any compressing force acting within the unopened cranium, *e.g.* hæmorrhage or tumour, must act by displacing (1) cerebrospinal fluid, (2) venous blood, (3) arterial blood, and finally driving the medulla downwards into the foramen magnum like a cork into the apex of a funnel, and by producing marked anæmia leads to (1) failure of the respiratory centre, and (2) failure of the cardiac and general vasomotor centre—of course, quickly ending in death. Death from this compression (in an unopened cranium) may be delayed by providing an opening in the cranial vault sufficiently large to relieve pressure. This fact is realised when we remove areas of the skull to relieve the patient from the effects of cerebral tumour; in hæmorrhage the operation has, unfortunately, only a small range of usefulness, and that almost limited to extra-dural extravasation, where the source of the bleeding can be dealt with. To act on the cerebral arterial pressure it is, as I have already stated, necessary to do so through the splanchnic vasomotor mechanism; physiologists have failed to produce any direct effect on cerebral arteries or arterioles by application of cold or any other means to the exterior of the head.

This broad fact has always been empirically acted upon in former days by bleeding and free purgation, and so impressed is this on the medical mind, early in its development, that the medical student is always prepared to place a few drops of croton oil on the tongue of the hemiplegic, while at the same time he advocates perfect rest and quietness, I suppose, until the medicament acts, when the unfortunate patient is sure to be well shaken during the efforts of the nurse to clean up.

By the term "simple concussion," is meant that slight degree of dizziness, staggering, and mental obfuscation that occurs on slight injury to the cranial mass, directly or indirectly applied; it is so momentary that we rarely see it in a patient unless present when it is produced. At one period or another, in school days or subsequently, most of us have experienced it. So quickly are all the slight disturbances over, and so complete the recovery, that it can hardly mean more than a temporary disturbance of pressure equilibrium in the brain and semi-circular canals. Without knowledge of the causative circumstances, it cannot be distinguished from slight syncope or shock. The treatment is simple; rest in the horizontal position soon restoring the cerebral functions.

Squeeze a man's thumb in a vice, hit him in the scrotum with a cricket ball, strike him in the abdomen with the fist, let the uninitiated look on at a surgical operation, or pick up a man who in falling strikes his head against the curbstone, and you will find them all suffering from the same symptoms which I quote from my article on Shock in *Encyclopædia Medica*:—

"He staggers towards a seat or falls, the lips become livid or bloodless, the skin pale, and there may even be partial loss of consciousness. Respiration may be temporarily suspended, then reappear in shallow gasps, wanting the relief of sighs. The heart beats feebly and frequently, and the pulse of course likewise. Surface temperature is much reduced, although the rectal temperature may only be down a degree or two. A cold perspiration bespangles the brow, and the individual exists by reason of the automatic action of his essential centres, the cardiac and respiratory—his

(*a*) Robert: Deutsche Militärärztl. Zeitschr. 1905. No. 5.

* A Clinical Demonstration given in the Out-patient Clinique of the Liverpool Royal Infirmary.

irreducible minimum. The patient loses heat in ordinary surroundings, and the feeble circulation means feeble oxidation of the tissues and deficient interchange of oxygen and carbonic acid. Continued exposure, particularly if the trauma be severe or continuous, will bring about a fatal result. All these symptoms are brought about by—

"1. Reflex paralysis acting on the heart through the medulla, leading to (*a*) slowing or even arrest of the heart's action, and (*b*) on the respiratory apparatus similarly.

"2. Interference with the action of the vasomotor apparatus, leading to a great fall in blood pressure; inspissation of the blood; interference with the interchange of O and CO_2 in the tissues, and loss of animal heat.

"3. Molecular change in the nerve cells bringing about fatigue and exhaustion.

"4. Hæmorrhage, if present, markedly influences all the above changes."

Direct injury to exposed brain in surgical operations, even removal of portions, or exploration, with necessary damage, does not produce any marked shock; neither does chiselling areæ of bone from the skull, even extensive resections, using a V chisel and heavy mallet with great force, cause "concussion"; provided the patient is fully anæsthetised, and no great hæmorrhage or prolongation of chloroform anæsthesia has been necessary. Why the difference in the effects with or without anæsthesia? What has the chloroform done? Simply destroyed the vasomotor reflex. Surely $CHCl_3$ ought to make no difference if direct concussion to brain is the cause of the symptoms usually described as "concussion." The injuries to other parts of the body previously mentioned, likewise under anæsthesia, do not produce shock. One is forced to the conclusion that the terms "shock" and uncomplicated "concussion" are really the same in cause, effect, and pathology.

Deaths may occur from shock just as from the same condition produced by head injuries, and leave no naked-eye pathological lesions. The treatment of this condition is to be carried out on exactly the same lines as we prescribe for shock—rest, quietness, warmth, and liquid nourishment, together with diffusible stimulants, digitalis, strychnine, &c.

The quieter a patient is kept, and the freer from worrying busybodies and friends, the quicker the recovery; a general hospital ward is not the ideal place; a darkened room or isolation ward, well warmed; quiet nurses, the absence of all noises, and the patient will quickly recover. Put an ice-bag on a patient's head in this condition, and you can keep him depressed and in his automatic state for almost as long as you renew the ice; you are only depressing the general blood-pressure, and going a long way towards "cold storing" his scalp. It has been shown that cold to the head can have no direct effect on the cerebral circulation, and it is difficult to understand how ice-bags or Leiter's tubes have still remained the stock treatment; they rightly belong to the era when it was thought necessary to prevent reaction (recovery) to take place too suddenly, and to prevent the onset of the feared inflammation of the brain. It is difficult to realise the great general depression produced by cold applications to the head. Let anyone try the effect of keeping the head under a running tap of cold water; the feeling of burning which quickly follows the initial cold sensation soon ends in faintness, great depression, and shock.

If the unfortunate patient be unconscious when the ice is first applied, he can be kept from "coming to" by diligently renewing the cold application. I have seen a patient on whose head ice-bags had been most assiduously applied for three weeks (with the simple exception of three hours, when the supply gave out, and he tried to struggle back to consciousness) reduced to the condition of a hibernating animal. Pulse 56, respiration 12, temperature 96°, the pupils reacted only slightly to strong light. He could be slightly roused by shouting in his ear to a dull perception of his surroundings, but immediately relapsed. He could swallow fluids poured slowly into his pharynx; and whenever his brain realised that the urinary bladder required emptying, he made feeble attempts to get out of bed, and would micturate into a vessel placed in contact with the penis. Notwithstanding such evidences of the struggles of his sensorium against this freezing treatment, it was continued for the time mentioned.

Following a consultation, the ice-bags were removed and a counter-irritant applied to the nape of the neck. He recovered so quickly as to overpower his female nurses, escaped downstairs, and did a "sprint" down a country road in the dead of night, when the temperature was low, and he was clad only in invalid garments. Despite an attack of acute rheumatism and pneumonia, he made in the end a perfect recovery.

Another case of a young boy, who, when diving into shallow water, struck the bottom and became "concussed." He was diligently "frozen" for ten days, and was in exactly the same condition as the previous patient. The removal of the ice, followed by counter-irritant to the back of the head by liniment of iodine, quickly brought about reaction and recovery; he sat up in bed next day, asked for, and obtained, a mutton chop from his anxious and excited mother. Did time permit, other cases could be mentioned.

What I have endeavoured to maintain is that shock and ordinary concussion are one and the same thing, that the same treatment applies to each, and ice bags are not indicated.

Severe concussion or continued unconsciousness implies definite naked-eye pathological lesions of the brain or meninges, contusion of the surface of the brain, and hæmorrhages into the meninges, or laceration of brain substance. The symptoms are different from those of ordinary surgical shock. Should the contusion or laceration be very extensive, basal or bulbar in situation, death is speedy; rapidly increasing unconsciousness (without conscious interval), twitchings, convulsions, paralyses, and progressive coma with stertorous breathing, when every respiration seems to be the final one, or Cheyne Stokes breathing, terminates the life of the patient. The pulse becomes slow and full, then falls in volume; the pupils dilate, and do not react to light.

Hæmorrhages occasionally occur in special motor areæ and lead to localising diagnoses, but they are often multiple and confusing from an anatomical point of view, *e.g.*, paralysis of one arm, with paralysis of the leg of the opposite side. It is well, therefore, to hesitate before undertaking operation, unless the diagnosis be lateral extra-dural hæmorrhage, which has decided symptoms and signs when uncomplicated. Rapidly increasing coma with complicated paralysis generally indicates multiple hæmorrhages and lacerations, and is beyond the range of practical surgery.

Can we differentiate between contusion and laceration? When the initial severe shock is over, certain points of assistance in diagnosis have been noticed. When the cortex is irritated by the extravasation we have marked irritability, restlessness, and other sensory disturbances, together with a busy delirium, very similar to mild delirium tremens. Twitchings or slight pareses may be present, rarely marked paralysis. Temperature is not affected—certainly not elevated. In average cases the patient does not drift into coma, but remains in a very "bear-with-a-sore-head" condition, called cerebral irritation; the patient lies in a universally flexed condition, he will answer when called to loudly, but the answer may not be quite what is expected, and is often interlarded with language lacking in style, or even decency. He will swallow liquid food poured gently into the pharynx, but is often very obstinate.

The treatment of this condition needs good nursing, firmness, tactfulness, and, indeed, muscular strength, for the sufferer frequently tries to get out of bed. Some form of restraint may be necessary, and sedatives are absolutely essential.

Ice-bags applied to the head are of service here, but

it should be clearly understood that their action is that of a general depressant, and not any fanciful therapeutic idea that they act directly on the cerebral circulation.

Chemical sedatives are preferable; very small doses of morphine (gr. $\frac{1}{4}$), repeated if necessary; in some cases hyoscine hydrobromate (gr. $\frac{1}{100}$) appears to be more useful; in one case where respiratory failure was threatening, hyoscine, atropine, and morphia, in suitable doses, were of marked benefit.

Chloral hydrate, in an initial dose of 20 grains, followed by 10 grains hourly, until its effect is produced, has been useful (this can be administered per rectum). If one drug loses its effect, another should be tried. Bromides seem powerless, and I now never prescribe them. It is important that the sensorium be calmed, and kept so; this is our sheet-anchor.

A chart, recording pulse, respiration, and temperature, should be taken, hourly if possible; and if a normal ratio between these three items be maintained, prognosis is favourable, provided the patient can be coaxed or forced to take sufficient nourishment. The cases last sometimes for weeks. The bowels must be attended to, but there is no need for drastic purgation.

Nourishment is of paramount importance from the earliest stage, to provide for the bodily wear and tear; for if the patient is very restless, marked emaciation soon shows itself. He must be cajoled by efficient nurses to take nourishment regularly. There soon comes a time when restlessness subsides and the sedatives are required less frequently. This is the opportunity, with return of consciousness, for dieting, and for administering *iodides*, which have a marked action in clearing up the muddy state of the patient's intellect, and preventing, I am sure, the after-effects so frequently mentioned in connection with concussion—headache, irritability, alteration of disposition, loss of memory, &c. The iodides probably act by hurrying the absorption of exudations. It is well to continue their administration for some time after the patient appears to be well.

I well remember a patient with severe headache and depression, who had been dosed with bromides without any good result, on being treated with iodides internally, remark that his pain went soon after beginning the "new medicine," and he used the expression that the medicine "wiped the slate clean."

Time will not permit of a lengthy consideration of cerebral laceration. Should this be extensive, the temperature rises rapidly (while the pulse and respiration remain fairly normal), and may become very high just before death.

Loss of bladder and rectum control, with rapidly increasing coma, is rare in contusion, but might be considered characteristic of laceration. A sudden rise of temperature is always suggestive of meningitis.

Time will not permit of a lengthy consideration of cerebral laceration in all its degrees and possible complications.

In conclusion: . it is a useful addition to treatment in all severe cases of head injury to clip the hair very short, or even to shave the head. This enables a thorough examination of the scalp, and renders the patient more comfortable.

It was not my intention to weary you with details of many cases, but to bring to your notice the deductions drawn from them.

THE OUT-PATIENTS' ROOM.

KING'S COLLEGE HOSPITAL.

SYPHILITIC DISEASE OF THE KNEE WITH CEREBRAL SYMPTOMS.

By PEYTON BEALE, F.R.C.S.

AMONGST the out-patients was a woman, æt. about 35, complaining of pain in the right knee which was especially severe at night. Her account was that the knee had been gradually swelling for the last fortnight with increasing pain, but she knew of nothing to account for the onset of the symptoms. The pain was worse after exertion. On examination, the right knee was swollen, there was no heat, movements were perfect and practically painless. The swelling was obviously in no way connected with the skin, and it certainly did not involve the periosteum or the bone. From the fact that the normal depressions around the patella were replaced by swellings, and that fluctuation was easily obtained in the joint, the patella floating, it was quite clear that the swelling of the knee was partly caused by synovitis leading to an effusion of fluid into the joint. It was also obvious that there was considerable thickening of the synovial membrane. No other joints were or had been affected. On further examination, several scars were seen below and to the inner side of the right patella, but no others were found in any part of the body. All attempts to elucidate any previous history of syphilis were quite unavailing, but Mr. Beale said that in spite of this he should at once assume that the scars were the result of gummata, and that the synovitis was probably also syphilitic. The patient was given mercurial ointment to rub into the skin over the knee, and 2 grs. of hydrarg. c. creta internally. Under this treatment the pain in the knee improved and the swelling began to subside. In a fortnight's time the patient complained of some weakness in her left arm and leg; she also had slight left facial paralysis. She was now given further mercurial inunctions in the form of mercurial ointment to be rubbed into the groins and axillæ on alternate days. The paresis became more marked during the next few days, but disappeared within a fortnight. Mr. Beale remarked that this case was in all probability one of gummatous infiltration of the synovial membrane, a condition not commonly met with. In the secondary stage a diffuse synovitis affecting joints successively was fairly common. As regards the paresis, he had little doubt that this was caused by some thrombosis really due to syphilitic endarteritis affecting some of the cerebral vessels, for its onset occurred at night during rest and was at first very slight in extent. He had often observed that these symptoms of thombosis were prone to occur amongst the earliest of tertiary symptoms, but the interesting fact was, he thought, that they commonly occurred in syphilitic cases in which the primary sore had been very small, and in which the secondary symptoms had been very slight indeed. It was sometimes stated that this was due to the fact that the primary sore had been altogether overlooked, so had escaped treatment; but he had come across several cases in which this cerebral thrombosis, as evidenced by slight one-sided paresis, often associated with headache, had appeared as the first tertiary symptom within eighteen months of the primary sore, which, although small and insignificant, had, nevertheless, been recognised and energetically and properly treated.

OPERATING THEATRES.

ROYAL FREE HOSPITAL.

PERFORATED DUODENAL ULCER, SUTURE, RECOVERY.—Mr. WILLMOTT EVANS operated on a man, æt. 45, who had been admitted two hours previously complaining of severe abdominal pain. The patient stated that at 10.30 in the morning he had been seized with a slight pain in the upper part of the abdomen a little to the right of the middle line, but the pain had not been sufficient to prevent his continuing his work; at 5.30, however, on the same day, the pain returned and became so severe that he had to go home. He was brought to the hospital some four hours later. At that time he complained of very severe pain in the site mentioned, sufficient to prevent him standing. On examination by Mr. Evans, the abdomen was found

extremely rigid, the right rectus being even more rigid than the left; percussion gave no abnormal signs except that the liver dulness seemed slightly diminished, the pulse was small, frequent and readily compressible, the patient was much collapsed. No history could be obtained of hæmatemesis or melæna. The diagnosis was made of perforation of some portion of the alimentary tract and a perforated duodenal ulcer was considered probable. Some delay was caused by the refusal of the patient to submit to operation, but at midnight, consent having been obtained, the abdomen was opened by a three-inch incision above the umbilicus in the middle line. The stomach was examined and found intact, but at the upper and back part of the duodenum, immediately external to the pylorus, was found a perforation about one-eighth of an inch in diameter; a little extravasated material was seen round the opening. Great difficulty was experienced in getting at the perforation, for many old adhesions existed fastening down this portion of the duodenum, and it was found necessary to make a horizontal incision from the middle of the first one. The opening in the duodenum was brought together by four or five fine silk Lembert's sutures, which turned in the edges of the perforation. Mr. Evans also thought it advisable to fasten over the area a small omental graft. The abdominal cavity was then flushed with large quantities of saline solution at a temperature of 105°. The wound was then closed, some little difficulty being experienced in getting the edges to meet; the patient was then returned to bed. Mr. Evans said that the diagnosis of this case was a probable duodenal ulcer which had perforated, the site of the pain and the sex of the patient being a little against a perforation of a gastric ulcer. In such cases as this it was unnecessary, he thought, to attempt to make a certain diagnosis, inasmuch as the abdomen must be opened. The only points of importance in the operation, he said, were the flushing and the absence of drainage. Some surgeons, he pointed out, had spoken against flushing the abdominal cavity with saline solution, as they maintained that it acted as a depressant. He thought that might well be the case if the saline solution were introduced at too low a temperature. It should not be forgotten that the normal temperature of the interior of the abdomen was 100° F., and therefore any fluid introduced must be at least as hot as that, but it was better, he considered, to have the saline solution at least two or three degrees higher, as its temperature would fall a little in passing from the irrigator to the abdominal cavity, and, moreover, some of the abdominal contents would become slightly chilled by the operation itself; he therefore thought it advisable that the water in irrigating should be between 105° and 106°. Saline solutions used to flush the abdomen had, he remarked, several functions. In the first place they diluted any toxins or micro-organisms which had already been introduced into the abdomen; in the second place, they, by their presence, tended to prevent the formation of adhesions; and in the third place, they provided a large quantity of normal saline solution, which could be absorbed readily by the lymphatics and capillaries, and so serve to keep up the blood-pressure. With regard to the other point of importance in the operation, *i.e.*, the absence of drainage, many surgeons, Mr. Evans said, considered it necessary to place drainage tubes in each flank and above the pubes in order to assist in carrying off some of the extravasated materials. There could be no doubt that openings such as those might assist greatly in the washing-out of the abdominal cavity, but, on the other hand, every such opening formed a fresh channel through which micro-organisms could enter the abdominal cavity; he therefore did not think it advisable to make drainage openings except in cases where the amount of extravasated material was especially great.

The patient progressed satisfactorily; sips of hot water were allowed after the first twelve hours, and liquid food was given at the end of the week; meanwhile the patient was fed by nutrient enemata. A little sloughing of a portion of the subcutaneous tissue at the edges of the incision occurred and delayed somewhat the healing of the cutaneous wound. In all other respects the progress of recovery was uneventful.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

GERMANY.

Berlin, Aug. 5th, 1906.

At the Surgical Congress, Dr. Bier, of Bonn, gave some of the results of his

Treatment of Inflammation by Artificial Hyperæmia (Bier's Stasis Hyperæmia).

He had, up to the present, treated 1,500 acute inflammation, 1,100 of which were treated by "suction" treatment, mostly slight cases. In 236 cases the stasis bandages were used; the other cases belonged to the earlier days of the treatment. Of the severer cases 25 were phlegmons of the sheaths of tendons, in which pus was present, 18 recovered without necrosis, 7 with partial necrosis. Almost perfect movement was retained in the first group of cases; amongst these were six severe phlegmons of the fingers; perfect function remained in four cases. In the cases recovered with necrosis, it was ascertained that the necrosis was present before the commencement of the treatment. It was true that early phlegmons had been successfully treated before, but generally without retaining good function, whilst in the cases treated with artificial hyperæmia the function was perfect in 50 per cent. Of 22 cases of acute osteomyelitis, 11 recovered with and 10 without necrosis (one died of pyæmia), but they were mild cases affecting small bones, and these results had been already obtained with free opening. Better results were, however, undoubtedly to be obtained when the stasis bandage was applied at the onset of the disease. More recently the results obtained in children at the commencement of the disease were quite satisfactory.

As regarded joints the traumatic suppurating joints were of special importance; of these the severest cases had recovered with unimpaired movement. 28 cases of suppuration of the ear were treated in this way, 27 of them complicated by mastoiditis; of 17 acute cases, *i.e.*, such as had not lasted more than two months, 16 recovered after slight incision in the mastoid process, with good hearing power, as was proved on examination by an ear surgeon. This was a warning to treat cases early. It was to be remarked, however, that stasis hyperæmia was not so simple a procedure; practice, care and conscientiousness were requisite.

As regarded less favourable results, he saw only partially good results in erysipelas, and this agreed with the observations of other surgeons. As regarded streptococcal diseases, he had but little experience, as they were very rare in Bonn. The view of Lexer that artificial hyperæmia acted well only in mild cases, uncertainly in moderate ones, and not at all in serious cases was not in accordance with many experiences, and just as little that the latter should be treated with extensive incisions. The joint should not be firmly fixed, as movement suffered by fixation; early active movement in a warm bath was recommended. Pain from the bandage was not a contra-indication; it resulted generally from imperfect technique. The most difficult part of the treatment was the determination of the indication; it required further working out.

He observed that at first he was called a mystic and a vitalist, to-day he was called a mechanic and an empiric; he would in the future endeavour to proceed scientifically.

A discussion on the subject was taken part in by a large number of surgeons. Indeed, if one may judge of the interest and importance of a subject by the number of people anxious to take part in a discussion of it, Bier's hyperæmia was the most interesting topic before the meeting.

Herr Habs, Magdeburg, discussed the contra-indications for it; these were erysipelas, venous thrombosis and the gangrene of diabetes.

Herrn Körte and Kruse, Berlin, had seen good results, but the latter not so in three severe cases of osteomyelitis. Herr Sietz, Hamburg, had treated 250 cases in this way. In most cases a good result was observed as regarded pain, fever and retention of function. Herr Stich, Breslau, reported "right favourable" results.

Herr Danielsen said that in Küttner's Klinik, Marburg, the treatment had been employed in 260 cases, and it had only failed in six owing to defective technique. After some days the treatment should be discontinued if no good result was obtained, and no large incisions should be made. He held the hyperæmic method to be the greatest surgical acquirement of recent times.

Herr Bardenhauer, Cöln, had practised the method for two years, at first with great reluctance, then through the agency of his assistants he became a fervid adherent to the system. At first he failed to retain movement in joints, but he was now successful. We should make only very small incisions as recommended by Bier. In this way seven cases of osteomyelitis recovered with power of movement in the joints, the same with bad phlegmons and furuncles. Here was used the suction treatment.

Herr Heidenhain had also had good results. He gave the two following rules: in the intervals between the bandagings the œdema set up should be allowed to subside and where pus was present small incisions should be made. The hyperæmia had an unconditionally anti-inflammatory action; the pus cocci died off. It had also a prophylactic action in amputations. Cicatrices after the hyperæmic process were uncommonly soft and were not distinguishable from the surrounding tissues.

Herr Perthes, Leipzig, said that the favourable action of hyperæmia could not be denied.

Herr Hoffmann, Carlsruhe, said the effect was very good in soiled wounds and compound fractures; the vessels were dilated and the leucocytosis diminished, but the chief thing was that the secretions were conducted outside.

Herr Kuster, Marburg, said that stasis hyperæmia was the most important advance in clinical surgery since Lister. It came in where aseptic treatment failed. Many other surgeons took part in the discussion, amongst whom were Ranzi, Vienna; Thöle, Dantzic; Haasler, Halle; Blumberg, Berlin, and others. All spoke favourably of the treatment. Lexer, of Konigsberg, the least so. The last-named gentleman seemed to take pleasure rather in dwelling on what it could not do than in contemplating its undeniably good effects when intelligently employed.

AUSTRIA.

Vienna, Aug. 5th, 1906.

A RETROSPECT OF CARCINOMA OPERATIONS.

WERTHEIM interested the Gesellschaft with a history of his operation in carcinoma of the uterus. He quoted 60 cases operated on five years ago, 60 operated on four years ago, and over that number for three years. Gynæcologists would admit that the first 60 were the most important, but it was interesting to note how different operations acted on the recurrence of the disease. In the distended vaginal operation it would appear that recurrence hardly ever takes place before that period (fifth year) after operating. For those over five years he had 60 per cent. entirely free from any symptom of recurrence, which he considered an extraordinarily favourable result when compared with previous operations. The statistics of all such operations per vagina, prior to Schauta, were always given as 20 or 25 per cent., and the very best recorded are 30 per cent. With this new vaginal operation every second woman operated on escapes for upwards of five years—hitherto only one in seven—even with extirpation of the uterus. According to Wertheim's last 90 cases, only 15 per cent. died two years after the operation and 9 per cent. after reaching one year.

Wertheim attributes this happy result to the present methods of operating for cancer in the neck of the uterus.

Extirpation by laparotomy keeps the patient far too long under the influence of the anæsthetic. Shorten the period of operating, and you extend the term of life. Make every preparation for expedition in clearing out the cancerous growth. Lumbar anæsthesia provides another excellent method of operating.

Wertheim has done 15 cases recently by the subcutaneous injections into the lumbar region with the best results; only one proved refractory, and inhalation had to be resorted to. He is now confident that distended vaginal operations for cancer in the neck of the uterus has obtained an abiding place in gynæcological surgery. He reminded his audience that five years is all that they can reasonably expect under very favourable circumstances.

Bürger said Schauta had introduced the vaginal method five years ago, and obtained very good results then which are now confirmed by Wertheim. It should be understood that the vaginal method before that time is not the vaginal method of to-day. Wider incisions are now made into the parametrium preparatory for the excision of the morbid growth. The glands are not extirpated in this operation, as it is very problematical whether they hasten or retard recurrence of the disease. Schauta's results were 50 per cent., while Wertheim tells us that his are 60 per cent. after five years, or, in other words, six times better than the old vaginal operation in vogue when Schauta commenced operating.

GLAND INFECTION IN CARCINOMA.

Latzko exhibited a number of preparations taken from the glands of patients suffering from uterim and vulvar carcinoma, and compared them with the glands taken from other parts of the body, such as the mamma, &c., where extirpation of cancer and glands were performed. The radical operation of cancer glands and vessels has not given the results expected. There is no improvement in the time limit. There is still a good deal of confusion about the iliac hypogastric and internal inguinal glands being in close connection with the uterus. Their presence does not appear to increase the danger of recurrence.

PSEUDO-BULBAR PARALYSIS.

Hoesslin records a case of diagnosed bulbar paralysis, which revealed at the post-mortem two apoplectic centres at the lower portion of the second and third convolution of the frontal lobe. The bulbus was examined microscopically and found perfectly entire.

MULTIPLE SCLEROSIS.

Selling records a case of multiple sclerosis, where the "main de prédicateur" of Charcot was the dominant symptom. The three outside fingers are bent, while the index and thumb are extended. The motor or anterior horn of the spine is admittedly injured, but this symptom was usually accepted in pachymeningitis cervicalis hypertrophica or syringo myelia as pathognomonic, but not in multiple sclerosis. Selling's history and pathological sections put it beyond dispute that the symptom of "main de predicateur" is not confined to pachymeningitis or syringo myelia.

THE Military Academy of Medicine of St. Petersburg has decided to admit no more Jewish students.

HUNGARY.

Budapest, Aug. 5th, 1906.

At the recent meeting of the Royal Hungarian Medical Society, Dr. Schmidt read a paper on

AUSCULTATORY PERCUSSION.

He said that lately a number of articles have appeared in the world's medical press, which tend to throw discredit upon auscultatory percussion as applied to the heart. Entirely faulty boundaries are obtained, it is assumed, and the varying tension of the skin will permit the percussion of heart-shaped figures even over other parts of the thorax. He asserted that this is due to faulty technique. He has made hundreds of examinations, and has controlled the accuracy of the method by means of the X-rays. Considerable experience is required, as skin-tension must be carefully avoided; the stroking should be practised with a fine brush, or, better still, with a small drum, which is rolled over the chest, and to which a brush is attached. Various drugs, warm baths, &c., undoubtedly cause a change in the cardiac contours.

In the *Orovsok Lapja*, Dr. Preisich published an able article on

ALBUMINURIA OF PUBERTY.

It is not generally known that a large percentage of boys from fourteen to eighteen years of age suffer from albuminuria without having nephritis. The author had the rare opportunity to examine repeatedly over 500 young employees of a large factory, and discovered albumin in no less than 19 per cent. In most cases, only traces could be detected, though in a few the amount exceeded 1 per mill. The greater part of the albumin seemed to consist of globulin as in acute nephritis, including the presence of wide meshes in the filtering apparatus of the kidney. The cause of the albuminuria, which generally had an intermittent character and was orthostatic in type, was to be found in an impoverished condition of the blood, together with a mild degree of cardiac insufficiency and tendency to stasis, such as is liable to occur during puberty, where the rapid growth of the body is out of proportion to the functional powers of the internal organs. In accord with this, dilatation of the heart, tension of the arteries, and accentuation of the second aortic sound were frequently noted. The condition is readily outgrown, since it was not found in any of the men above twenty-five years old of the same factory. It is often difficult to distinguish from chronic interstitial nephritis, but the slightest amount of albumin, the rare occurrence of casts of hyaline character and the distinct intermittent type speak against the latter. Moderate cardiac changes are of no value, as they occur in both.

Dr. Landoer has studied the congealing point of the blood-serum under various conditions, in order to determine to what extent this may be looked on as index of renal function. Unfortunately his results tend to minimise the practical importance of cryoscopy. It appears that food has little influence; thus with a strict milk diet normal figures were obtained, though the serum was considerably poorer in nitrogen than before. This nitrogen loss depended upon a deficiency of albumin; since albumin, however, consists of very large molecules, no variations in the freezing-point below 0.58 C. seems to point to a retention of excrementitious products, but normal figures indicate renal sufficiency only if the serum is not poorer in nitrogenous substances. Even in uræmia and advanced nephritis, cryoscopy may give no clue as to the condition of the kidneys, since a dilution of serum occurs which compensates for any change. This fact will limit the usefulness of cryoscopy in surgery considerably, unless accompanied by a chemical examination of the serum. Occasionally the latter will also yield normal results in nephritis, but here the compensation is perfect. The influence of fever, as in typhoid, pneumonia, &c., is not constant, as the pressure may be normal, increased or diminished without any relation to the nature of the disease. In diabetes, the freezing-point was generally found subnormal, owing to the presence of glucose, acetone and diacetic acid in the serum. In pernicious anæmia, the serum congealed at a somewhat higher temperature than normal, owing to larger amount of water present.

LETTERS TO THE EDITOR.

TRANSMISSION OF SYPHILIS

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Whatever in my knowledge of syphilis I account most exact and valuable I owe to the teachings of Mr. Jonathan Hutchinson; and the experience of many years has proved to my satisfaction the correctness in the main of his views. On numerous occasions in former years you have allowed me to take part in discussion of the subject in your columns. The last of these occasions was in March 1897. I have always contended that the injurious effects of syphilis have been often greatly exaggerated. It would be probably going too far to say that syphilis in men of good constitution leading temperate, healthy lives is rarely a very harmful disease even when not energetically treated; but it is not too much to affirm that the great majority of such cases after systematic treatment by a properly directed course of mercury extending over a sufficiently prolonged period, may be considered cured, so rare is the appearance of any subsequent serious symptoms. It is almost solely in patients of bad constitution or intemperate, dissipated habits that the disease runs a malignant course. I am satisfied, however, that general paralysis and locomotor ataxy are much more common sequels of cases which have not undergone thorough mercurial treatment than of those in which this treatment has been persevered in to the satisfaction of a vigilant surgeon. With regard to the transmission of syphilis, I believe that a syphilitic father whether he has been thoroughly treated or not, seldom begets tainted offspring after disappearance of the secondary symptoms, say after lapse of two years from the date of primary infection. Of this fact I could bring forward many cases in proof. With efficient mercurial treatment during the first two years I am convinced that the danger even immediately afterwards of producing infected children is very small, and that after the lapse of another two years even in cases where symptoms persist and are constantly treated by mercury and iodide of potasium, the danger of transmitting the disease can no longer be said to exist.

I have examined many thousands of children in hospital practice in my time, and the number presenting unequivocal signs of syphilis even among the progeny of undoubtedly infected parents has been very small. "Scrofula" tuberculosis and rickets are often mistaken for syphilis, and among minor signs "honeycombed" teeth—teeth with rough, imperfect enamel or spinous crowns—are often mistaken for the typical teeth originally described by Mr. Hutchinson. These latter teeth when present form an unequivocal sign of syphilis; but they are by no means found invariably even in children unquestionably the subjects of inherited syphilis. Typical syphilite teeth are very rare; they are not discoverable in more than five per cent. of tainted children. Syphilis is responsible for so much unhappiness that it will be well when some portion can be reduced through the general appreciation and acceptation of Mr. Hutchinson's views so admirably set forth in the clinical lecture published in your issue of August 1st. If this were the case a less pessimistic prognosis would more often be given to young men contemplating matrimony. Many a life has been spoilt for lack of authoritative assurance that marriage after syphilis need not necessarily involve any danger worth considering to either wife or progeny, much less to a third generation.

I am, Sir, yours truly,

AN AVERAGE PRACTITIONER.

August 2nd, 1906.

THE MYSTERIES OF THE CANNED MEAT TRADE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The case heard at Lambeth Police Court on August 3rd forms perhaps the most revolting story as yet publicly unfolded of the mysteries of the canned meat trade. The newspaper reports do not make it quite clear what were the quantities of suspected meat from the same source reaching the market weekly, but as one dealer deposed that he was receiving fifty-two tons a year, the amount disposed of may have been enormous. The seizure in the present case amounted to about 106 pounds. Dr. Bousfield stated that the sample of "beef or brawn (?)" which he examined contained an abscess cavity filled with pus. The meat had been dyed with aniline dye. The consignments of meat came from Wolverhampton, not Chicago, but the efforts to trace the man who deliberately prepared and disguised the diseased carcase, had failed. The holders of the canned stock were able to satisfy the magistrate as to their honesty and *bona fides*, and beyond the infliction of a nominal penalty for carelessness upon one of them, the prosecution broke down. Under the public Health Act, proceedings can be taken only against a dealer in whose hands the bad food is found and the firm from whom he bought it. In this case neither of the parties summoned were primarily responsible, nor was guilty knowledge proved against them. The case serves to show once more how defective are our sanitary laws, and how they serve in many cases merely to give an entirely false sense of security to the public. The public cannot imagine that elaborate codes of laws may appear on the statute-book devised to protect their interests, whilst no adequate machinery has been provided to enforce them. Laws against the sale of unwholesome and adulterated food are provided, therefore articles of food are pure; so reasons the average householder, and this confidence provides the opportunity for the fraudulent tradesman. It would be satisfactory if there appeared any prospect of legislation which should effectually put a check upon practices so injurious to the health of the nation, but no such prospect is in sight.

I am, Sir, yours truly,

VIGILANS.

MOTOR-CARS AND DUST.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—As a sufferer from motor dust (and who is not), and as a member of the same profession as Dr. Gilchrist, I beg to join issue with him in his championship of motors. I happened to be staying at Matlock last week when reading his letter in your issue of August 1st, and the dust raised by passing motors was so terrible that I preferred to change my quarters rather than spoil my holiday by breathing the dust-laden atmosphere created by them. Your correspondent maintains that "it is the horse pounding with his iron hoof, and the metal wheel of the vehicle he draws that are responsible for the conditions you justly condemn." If this be so, how is it the dust nuisance has become so intolerable the last year or two, that special legislation has been found necessary to control its origin, and that people living in main roads most traversed by motor-cars are giving up their houses and removing to side streets not patronised by the modern Jehu?

Dr. Gilchrist writes from Nice. I, too, know the Riviera well, and my opinion when last there, two years ago, was that Nice and other beautiful health resorts along the Mediterranean, were being utterly ruined by the modern curse of civilisation—"motor dust."

I am, Sir, yours truly,

J. WILSON.

August 6th, 1906.

MR. CHARLES LEEDHAM-GREEN, M.B., F.R.C.S., was appointed honorary surgeon to the Queen's Hospital Birmingham, in place of Mr. Bennett May, resigned.

OBITUARY.

PAUL BROUARDEL,

PROFESSOR OF FORENSIC MEDICINE AT THE UNIVERSITY OF PARIS.

BY the death of Professor Paul Brouardel on Monday, July 23, the Faculty of Medicine of Paris loses one of its best known members. Born at St. Quentin in 1837 he took his degree at the Paris Faculty in 1875. He was appointed professor in 1879, and attained that much coveted distinction of election as Member of the Academy of Medicine in 1880, followed in 1892, by membership of the Academy of Sciences.

The Professor was a pupil of Tardieu, whom he succeeded after a comparatively short "stage." His name is associated principally, though not exclusively, with legal medicine and public hygiene. His reports as medical expert delegated by the tribunals attracted attention by the care, skill and method with which they were put together, and directly he was appointed lecturer on forensic medicine, left vacant by the death of Tardieu, he at once inaugurated a series of practical lectures at the Morgue, which were highly appreciated by many generations of students and practitioners in spite of the exiguity of the accommodation and the insalubrity of that famous, if lugubrious, building.

He was elected president of the Comité Consultatif d'Hygiene in 1884, and became Dean of the Faculty of Medicine in 1886, in addition to which he filled many official posts, so that he led a very busy life. In spite of this he devoted much time and thought to medical deontology *alias* medical ethics, and his works and contributions on the subject are known world wide. The English conception of professional secrecy is so fundamentally different from the French that the author's utterances found little echo on this side of the Channel.

He was constrained to relinquish work last winter in consequence of chronic laryngitis, and when the disabling tendency of the disease became manifest he went to live in the south of France. He leaves a widow without children.

Dr. Brouardel's great merit in the eyes of posterity will be that he was from the first one of the few to grasp the pre-eminent importance of hygiene as a factor in the public weal. He unhesitatingly threw his very great influence into the scale and did much to educate the public, and even the profession, in the principles of personal and national hygiene.

The funeral took place amid a great gathering of colleagues, friends and admirers.

DR. ANDREW D. DUCAT.

MUCH regret is felt at the death of Dr. Andrew D. Ducat, which occurred, in his 68th year, at Grosvenor-road, Canonbury. A native of Arbroath, he graduated M.D. at Edinburgh in 1863, and held for thirty-nine years the position of medical officer for the Highbury district. He was an elder of the Park Church (Presbyterian), Grosvenor-road, and an honorary president of the London Forfarshire Association.

EDWARD FRANCIS WILLOUGHBY, M.D., D.P.H.

WE regret to announce the death of Dr. Edward Francis Willoughby, honorary medical officer to the Mansion House Council on the Dwellings of the Poor, who passed away on July 29th at his residence, Bratton Lodge, Finsbury-park, after only a week's illness, in his sixty-seventh year. Educated at University College, London, he took the M.B. degree with honours at London University in 1869, the diploma in public health both at London and Cambridge in 1881, and proceeded to the M.D. degree at London University in 1889. Dr. Willoughby was a well-known contributor to medical literature, and published many works on hygiene. He also edited "Chaucer's Prologue to the Canterbury Tales."

EDWARD MACKEY, M.D.Lond., M.R.C.P.

Dr. Edward Mackey, of Hove, senior physician to the Sussex County Hospital, died on July 29th in London, after a short illness. The son of the late Mr. Edward Walter Mackey, of Erdington, he pursued his professional studies at Queen's College, Birmingham, afterwards becoming physician and Professor of Materia Medica and therapeutics at the Queen's Hospital in that city. He was also at one time physician to the Birmingham and Midland Counties Hospital for Sick Children. On going to Brighton he was appointed assistant physician to the Sussex County Hospital, and honorary physician to the Royal Alexandra Hospital for Children at Brighton. Dr. Mackey enjoyed a large consulting practice at Brighton and was widely respected.

LITERARY NOTES.

As the result of investigations extending over a period of many years Sir Almroth E. Wright, M.D., F.R.S., has written a book which Messrs. Archibald Constable will shortly publish for the use of students using the microscope. Hitherto this instrument has been too commonly treated by rule of thumb, and without those considerations of the principles of microscopic technique which are so essential to the attainment of accurate and scientific results. The object of the book is to show how best to get from any class of instrument the highest degree of satisfaction in proportion to its range. The text of the whole book goes hand in hand with experiments. The work also contains a complete vocabulary of technical terms relating to the microscope.

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A clever little book has been brought out by the Lemco Company, called "New Dinner and Luncheon Dishes." In it are described the many uses that "Lemco" may be put to, uses which strike us as being as ingenious as we have no doubt they are appetising.

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REVIEWS OF BOOKS.

PATERSON ON GASTRIC SURGERY.(a)

Mr. Herbert Paterson has amplified his Jacksonian Prize Essay and issued it, with additional references, in book form, under the title of "Gastric Surgery." The book is divided into two parts, a first part consisting of three lectures, and a second part containing details of the operation of gastric jejunostomy including preparation and after treatment, and ten tables of collected cases showing the after results of gastric operations. These tables are a valuable addition to the literature of gastric surgery and must have entailed a great amount of labour. In the first part we have a well-reasoned argument in favour of the surgical treatment of gastric disorders, "hæmorrhage," and "cancer" being particularly well handled. The book is, as it were, written round the operation of gastro-jejunostomy, the anterior method being recommended, though Mr. Paterson's reasons may not seem conclusive to all. He very rightly insists on the necessity of a wide anastomotic opening, and he considers regurgitant vomiting and peptic jejunal ulcer to be due to insufficiency in this respect. There will be a considerable difference of opinion on the suggestion that an immediate gastro-jejunostomy should be done in cases of perforated gastric ulcer, and it is very doubtful whether the performance of gastro-jejunostomy would justify one in omitting to look for and close a second perforation. In the case of ulcer near the pylorus, where invagination may be impossible, we are, however, quite in accord with the author in the necessity for a gastro-jejunostomy if the patient's condition will allow. The book is clearly printed, is easy to read, and, with its many references, will prove of value to those interested in this branch of surgery.

(a) "Gastric Surgery." By Herbert J. Paterson, M.A., M.B., B.C. Cantab., F.R.C.S.Eng. London: Ballière, Tindall and Cox, 1906. Pp. 112, with appendix 1906.

EXPERIMENTAL BIOLOGY OF AQUATIC ANIMALS. (a)

South-west Germany is fortunate in having at the present time a number of talented investigators, who are concerned with problems more or less of a biological nature. J. V. Uexküll belongs to this group, and the book before us which he has written is one of great interest, replete on every page with facts given in an original and attactive way. The work does not claim to be nor is it a full account of the biology of aquatic animals. The author very commendably confines himself to his personal experiences in a field which he has evidently well worked.

The book begins with an introductory part in which the scope of experimental biology (as contrasted with that of zoology or physiology) is defined. It then passes on to consider the "Reflex" at considerable length, regarding it as a response to the influences of environment. The treatment of this fundamental biological function is original and admirable in every way. Incidentally, it may be mentioned that the view of the structure of the nervous system adopted is that known as the "neuro-fibrillar."

The second part of the work contains a condensed account of "Methods," in which a description is given of certain special apparatus useful for the holding and observation, &c., of aquatic animals. The book ends with short notes of the series of animals mostly invertebrates, upon which observations are to be made.

Altogether, it is a work of convenient compass which will amply repay perusal by the biologist, the zoologist, and the physiologist alike. It is to be hoped that an English translation of it will soon appear.

ALLBUTT'S PROFESSIONAL EDUCATION (b).

This address is now for the first time published in full, as only about two-thirds of it was delivered by the author at the time. The theme of the essay is Medical Education in London. No one is able to speak with greater authority on this subject than the author. For our nation, he thinks that a State portal, in the directest sense, would be too cold-blooded, and might indeed, become too rigid for us. In the United Kingdom, at least the State should entrust the testing of medical efficiency to certain medical corporations under the supervision of the General Medical Council, and its tests should be for safe practice rather than for large attainments. Allbutt regrets that not every student of medicine has the opportunity of having a university education. He considers five years all too short a period for training and preparation with a view to the student's life-work. He refers to the fact that the old pill and bottle of our forefathers is being menaced by newer methods such as massage electricity, hydropathy, the sanatorium, the Nauheim business, and so on, methods which are often beyond the scope of the family physician. He concludes with the somewhat pathetic remark that at his time of life he may never again address so important a body of students as those of King's College, and therefore feels it his duty to touch upon certain matters relating to the higher life without which we can never prosper either as a nation or as individuals.

This essay is well worth reading if only with a view to finding out how one who has spent his life in the interests of medical science looks now at the position of professional education as existing in this country. Allbutt knows how to write, and his words carry weight. It were well if educational authorities as well as students and practitioners laid to heart the many words of wisdom contained within this delightful book.

(a) "Leitfaden in das Studium der Experimentellen Biologie der Wassertiere." By J. V Uexkull, Heidelberg. With 15 figures in the text. Wiesbaden: J. F. Bergemann, 1905. Pp. vii. and 130.

(b) "On Professional Education. With special reference to Medicine." An address delivered at King's College, London, on October 3rd, 1905. By T. Clifford Allbutt, M.A., M.D., F.R.S., etc., Regius Professor of Physics in the University of Cambridge. London: Macmillan and Co., Ltd., 1906. 2s. net.

MEDICAL NEWS IN BRIEF.

British Medical Association.

THE 74th annual meeting of the British Medical Association will be held at Toronto, Canada, on August 21, 22, 23, 24, and 25 next, under the presidency of Dr. Richard Andrews Reeve, Dean of University of Toronto Faculty of Medicine. This will be the second time that the association has met in the Dominion. Thirteen scientific sections have been arranged, and will meet daily in the University buildings at 9.30 a.m.—namely, anatomy, dermatology, laryngology and otology, medicine, obstetrics and gynæcology, ophthalmology, pædiatrics, pathology and bacteriology, physiology, psychology, State medicine, surgery, and therapeutics. On Tuesday, at 2.30 p.m. an address of welcome will be accorded to members, and the ceremony of introducing the distinguished guests and delegates will be performed. This will be immediately followed by the presidential address by Professor Reeve. At 4.30 p.m., in the University quadrangle, a reception and garden party by the president and Mrs. Reeve. At 8.30 an address in obstetrics will be delivered by Dr. W. S. A. Griffith, of London, while at 9.30 the Lieutenant-Governor will receive the members of the association. On Wednesday, at 2.30 p.m., an address on medicine will be delivered by Sir James Barr, of Liverpool; and in the afternoon various garden parties have been arranged. In the evening, at 8.30, an address on surgery will be delivered by Sir Victor Horsley, and this will be followed by a reception, at 9.30 p.m. On Thursday afternoon garden parties have also been arranged, while at 7.30 p.m. the president will preside at the annual dinner, when a most distinguished gathering is assured. On Friday afternoon extensive entertainments are promised to members and their friends, while in the evening will be held a grand *soiree*. On Saturday, August 25, several excursions are arranged—to Niagara Power Company's plant, through the courtesy of Sir Henry M. Pellat; to Muskoka; and to Lambton, through the courtesy of the president, Mr. Austin.

Irish Medical Association.

THE Committee of Council met in the Royal College of Surgeons on the 24th ult. They further considered the case of the medical officers of Limerick Union, who had been refused payment of the increase in salary granted by a former meeting of the Guardians, and already sanctioned by the Local Government Board. The law adviser of the Irish Medical Association applied to the Board of Guardians to carry out the terms of the resolution, and stated that they must understand that they had no power to modify in any way the terms of the resolution referred to. The Committee decided that, if necessary, the law adviser be authorised to take proceedings against the Guardians.

London Hospitals Sunday Fund.

A MEETING of the Council of the Metropolitan Hospital Sunday Fund was held on Thursday last under the presidency of Alderman Sir Horatio Davies. The report of the Committee of Distribution of the Council recorded with gratitude that Mr. George Herring had again offered to add one-fourth to the amount collected in places of worship, as well as to the City collection. The amount of the fund to the present time was £56,303, to which had to be added £3,000, a portion of the legacy of £10,000 left to the fund by the late Mr. Herbert Lloyd, making a total of £59,303. This year 250 institutions had made applications for grants, being two more than last year. The committee recommended the distribution of £57,510, to the 161 hospitals and institutions, sixty dispensaries, and twenty-six nursing associations. Also that the award to Charing Cross Hospital be paid when it is proved to their satisfaction that the result of the special appeal to be made next autumn will enable the committee to carry on the work of the hospital, and that the grant made last year be now paid to the City Orthopædic Hospital, without waiting for the amalgamation to be carried through. Five per cent. of the total sum collected is set apart to purchase surgical appliances. The report was unanimously adopted, and after votes of thanks had been passed to Mr. George Herring for his generous and continued interest in the Fund; to the committee of distribution for the care bestowed in the preparation of the awards; to the Lord Mayor for his devotion of so much time to the well-being of the Fund as president and treasurer; and to Sir Horatio David Davies for presiding, the meeting terminated.

The Caledonian Medical Society.

THE twenty-sixth annual meeting of the Caledonian Medical Society was held at Stirling on July 13th under the presidency of Dr. W. A. Mackintosh of Stirling. There was a representative attendance from both sides of the Border. The honorary secretary (Dr. Macphail of Derby) gave in his report, which showed the membership to be 232, or double what it was ten years ago. Financially also the Society was stronger than it ever had been, and the journal published quarterly by the Society had increased its circulation. Dr. Andrew Little, of Bradford, was elected president for the ensuing year. In his presidential address Dr. Mackintosh spoke of the present position and prospects of the Gaelic language, and his address was an able and forcible plea for the teaching and study of Gaelic. The annual dinner was held the same evening, the menu card, designed and beautifully illustrated with local views by Mr. J. G. Murray, was entirely in Garlic, a motto from Galen in the original Latin, with an old Gaelic translation from a curious and valuable MS. in the president's possession appeared on the frontispiece, which also showed the crest of the Society—an armed Highlander battling with the skeleton Death, and the motto "Is Righ Gach Slan?" The toast of the evening was proposed in a racy and witty speech by the Rev. Lachlan Maclean, Alloa, a well-known celt and poet.

Lady Doctor for St. Helens.

ON July 26th at the meeting of the St. Helens Health Committee the Medical Officer submitted the definition of duties and the draft advertisement for a lady doctor for the borough, who will assist the medical officer of health, and deal especially with the school children. The Chairman said he had asked the doctor to put down the salary at £160, rising to £200 by two annual instalments. This was in accordance with what was being done in other parts of the country, and probably in a year or two they would have to pay more. The proposition was agreed to.

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 July 27th. There were present: Dr. de Havilland-Hall, in the chair; Dr. J. Brindley James, Mr. F. S. Edwards, Dr. F. S. Palmer, Dr. St. Clair, B. Shadwell, Mr. Edward Bartlett, Dr. M. G. Biggs and Mr. J. F. Colyer. The accounts presented to the Committee were very satisfactory, showing that in

the past half of the current year the sickness experienced by the Society has been considerably less than in the corresponding period of 1905. The result has been an appreciable increase in the financial strength of the Society, the funds of which now amount to over £200,000. The amount paid away in sickness claims now exceeds £10,000 per annum, and about one-fifth of this is paid in annuities to members who are permanently incapacitated from professional work. Prospectuses and all particulars on application to Mr. F. Addiscott, Secretary Medical Sickness and Accident Society, 33, Chancery-lane, W.C.

International Exhibition of Hygiene.

Burroughs, Wellcome and Co. have followed up their successes at St. Louis and Liége by obtaining a gold medal at the International Exhibition of Hygiene held during the months of May, June and July at the Rotunda in the Royal Prater, Vienna.

Army Medical Service Reform.

One part of Mr. Haldane's scheme of Army re organisation has already been taken in hand by the Aldershot Army Corps—namely that referring to the Royal Army Medical Corps service. An experimental field ambulance has been formed, and is now encamped at Frensham, with the 1st Division as a trial. Colonel H. N. Thomson is in command, and the whole hasbeen inspected by the Duke of Connaught. The new organisation promises to simplify medical service in the field.

PASS LISTS.

Royal College of Physicians of London.

At the ordinary quarterly *comitia* of the Royal College of Physicians of London, held on July 26th, the President, Sir R. Douglas Powell, occupying the chair, the following Fellows were elected officers of the college :—Censors.—Frederick T. Roberts, M.D., Sir Thomas Barlow, M.D., J. Mitchell Bruce, M.D., T. Clifford Allbutt, M.D. Treasurer.—Sir Dyce Duckworth, M.D. Emeritus Registrar—Sir Henry A. Pitman, M.D. Registrar—Edward Liveing, M.D. Harveian Librarian—J. Frank Payne, M.D. Assistant Registrar—Oswald A. Browne, M.D. Library Committee—Norman Moore, M.D., William Osler, M.D., Archibald E. Garrod, M.D., Humphrey D. Rolleston, M.D. Curators of the Museum—H. Charlton Bastian, M.D., William Cayley, M.D., W. Henry Allchin, M.D., Seymour J. Sharkey, M.D. The following were elected examiners in the subjects indicated for the ensuing collegiate year :—*First Examination*—*Chemistry*—J. M. Thomson, F.R.S., G. Senter, Ph.D., B.Sc. *Physics*—J. A. Gardner, F.C.S., F.I.C., F. T. Trouton, F.R.S. *Materia Medica and Pharmacy*—C. Ogle, M.B., J. J. Perkins, M.B., R. A. Young, M.D., J. P. Stewart, M.D., O. F. F. Grünbaum, M.D. *Physiology*—W. D. Halliburton, M.D., E. H. Starling, M.D., B. L. Abrahams, M.B. *Anatomy*—P. Thompson, M.D., R. Howden, M.B. *Medical Anatomy and Principles and Practice of Medicine*—F. de H. Hall, M.D., T. D. Acland, M.D., G. N. Pitt, M.D., W. Collier, M.D., H. M. Murray, M.D., N. Dalton, M.D., H. D. Rolleston, M.D., F. J. Smith, M.D., A. P. Luff, M.D., W. E. Wynter, M.D. *Midwifery*—F. H. Champneys, M.D., J. Phillips, M.D., H. R. Spencer, M.D., W. J. Gow, M.D., T. W. Eden, M.D. *Public Health*—W. H. Willcox, M.D., A. G. R. Foulerton, F.R.C.S. The following, having passed the required examinations, were admitted to the membership :—John Telfer Calvert, M.B., Lond., L.R.C.P., St. Thomas's Hosp., Major I.M.S., Bengal; T. E. Cecil Cole, M.A., M.D., Oxford and St. Bart.'s; Henry Roy Dean, M.B., Oxford, L.R.C.P., Oxford and St. Thomas's; G. W. Ross, M.B., Toronto, L.R.C.P., Univ. of Toronto. The Moxon gold medal, instituted in memory of Dr. Walter Moxon, and awarded every third year to the person who should be deemed to have most distinguished himself in observation and research in clinical medicine, was awarded to Jonathan Hutchinson, F.R.C.S., LL.D., D.Sc., F.R.S. The following have been appointed lecturers for the year 1907 :—Milroy, Dr. Leonard Rogers, of Calcutta; Gulstonian, Dr. E. Farquhar Buzzard; Lumleian, Dr. G. H. Savage; Oliver-Sharpey, Dr. Halliburton; Croonian, Dr. W. J. R. Simpson; FitzPatrick, Dr. P. H. Pye Smith. The Bradshaw lecture will be delivered next November by Dr. S. J. Sharkey, the FitzPatrick lectures by Dr. Norman Moore, and the Horace-Dobell by Dr. F. W. Andrews during the same month.

Royal College of Physicians of Edinburgh, Royal College of Surgeons of Edinburgh, and Faculty of Physicians and Surgeons of Glasgow.

The final examination of the above board, held in Edinburgh, was concluded on July 23rd, when the following candidates were successful:—

Mary Deborah Hancock, Surbiton; Khorshed Sorabji Kanjá, Bombay; John Andrew Kane, Toronto; Thomas McLaren Galloway, Kirkcaldy; Michael Gavin, Dunfermline; Ernest Martin, Alcester; Leonard Clarke Webster, Launceston; William Wallace Dunlop, Edinburgh; David James Melville Legge, Dundee; Henry Albert Pascoe, Durban; Edward Albert Williams, Chester (with Honours); Walter Scott, Canada; John Alfred Steele Phillips, India; Gustavus Herbert Powell, Co. Cork; Leopold Henry Gill, Gibraltar; Patrick Raoul Eskell, Port Elizabeth; John Owen Shircore, India; Thomas Alexander Gregg, Co. Antrim; Carlo Ferruccio Fiaschi, New South Wales; William James Geale, New South Wales; Constance Helena Colley, Ireland; William Dunseith Dickson, Ireland; and Sydney Frank Henderson Everill, Worcester; and two passed in Medicine and Therapeutics, two in Surgery and Surgical Anatomy, twelve in Midwifery, and nine in Medical Jurisprudence.

Royal College of Physicians and Surgeons of Ireland.

Final Professional Examination.—The following candidates have passed this examination :—John Burke, Timothy Alexander Burke, Richard Calnan, Michael John Coyne, Myer Cohen, Joseph Daniel, William Joseph Deighan, Patrick Francis Foran (with honours), Thomas Joseph Galligan, Jermiah Grace, William Glennan, David Gillies, Abraham Hipwell, William Patrick Kelly, Thomas Hunter Massy, Patrick Mullany, William John McCormick, Kevin P. Neary, Joseph O'Donnell, Thomas Thaddeus O'Farrel Dominick Thomas O'Flynn, Gerard Petit, Edward Philip Punch, William Christopher Townsend Robey, Joesph Richard Tobin, William Walsh, Charles Hope Waddell, Mortimer Walters, Joseph Maxwell Warneck, Rupert Weply, Charles Henry Wilson.

Examination for the Diploma in Public Health.—F. W. Brunker, L.R.C.P. and S.I., E.S.R. Cadman, M.D.Edin. F. J. Cahill, R.C.P. and S.I.; Major T. W. Irvine, I.M.S., F.R.C.S. Edin. (with honours); Edward McDonald, M.B., R.U.I.; the Hon. Ella Scarlett Synge, L.S.A., M.D. (with honours).

London School of Tropical Medicine.

The following candidates passed the final examination of the London School of Tropical Medicine, held at the end of the twenty-first session, July, 1906 :—Capt. L. P. Stephen, I.M.S., M.B., Ch.B. (Aberdeen) D.P.H. (Lond.); L. A. Prins, L.M.&S. (Ceylon), L.R.C.P.&S. (Edin.), Colonial Service; Capt. A. W. Cook Young, I.M.S., M.B., Ch.B., D.P.H. (Aberdeen); Major E. Wilkinson, F.R.C.S. (Eng.), L.R.C.P., D.P.H. (Camb.) all with distinction. W. S. Allan, M.B., Ch.B. (Glasgow), R. T. Booth, M.B., B.Ch. (R.U.I.), I. McW. Bourke, M.R.C.S., L.R.C.P., Colonial Service; John Cross, M.B., Ch.B. (Glasgow), Colonial Service; B. M. Flood, L.R.C.P.&S. (Edin.), Colonial Service; E. N. Graham, L.R.C.P., F.R.C.S. (Edin.); E. M. Nicholl, M.B., C.M.(Edin.); J. Ottley, L.R.C.P.&S. (Edin.), (Staff-Surgeon R.N. retired); E. C. Peake, M.B., Ch.B.(Edin.); E. Robledo, M.D. (Colombia, S. America); Miss L. G. Thacker, M.B., B.S. (Lond.), Capt. L. L. G. Thorpe, R.A.M.C., L.S.A.; A. B. Tighe, M.B., B.Ch. (Dublin); W. M. Wade, M.B., B.Ch. (Dublin); Miss K. Wyss, M.D. (Zurich).

WEEKLY SUMMARY OF THE MEDICAL JOURNALS. ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT LITERATURE OF PHYSIOLOGY AND PATHOLOGY.

The Theory of Opsonins.—The literature on opsonins has increased to such an extent, and is at the same time so scattered, that a brief recital of the present state of our knowledge is very opportune. Ross (*British Medical Journal*, July 7, 1906) publishes an address on the subject which is both interesting and comprehensive. Wright and Douglas, as long ago as 1903, showed that the success of the leucocytes as regards phagocytosis, was due, not to any inherent quality, but to the presence in the serum of certain bodies, called by them, "opsonins," which by their action on the invading organisms render the latter an easier prey to the leucocytes. These bodies are specific to the invading organism, and are distinct from bacteriolysins, agglutinins, and antitoxins. In order to estimate the amount of these bodies present, an actual experiment in phagocytosis is made *in vitro*, and the result examined under the microscope. All observations are made by comparison with a normal serum. The ratio of the opsonic activity in the blood under investigation to that of normal blood is spoken of as the "opsonic index." A few general facts have emerged regarding the relation of the opsonic index to infection. If the infection be strictly localised, the opsonic index is, as regards the infecting organism, below normal. If the infection be more general, the index is likely to be more variable, falling from high to low, and rising again, in an irregular manner. A high opsonic index is in itself a sign of a good, though possibly insufficient, reaction on the part of the constitution. The object in the treatment of local infections is to obtain a good reaction, of which the sign most readily recognizable is a high index. The reaction is excited by the inoculation of the subject with a suitable dose of dead bodies of the organism with which he is already infected. The first point, then, to establish in attempting to apply our knowledge of opsonins to the treatment of disease, is to discover the infecting organism. When this has been done, and the opsonic index in relation to it estimated, then a dose of the organism, having been killed by heat at 60° C., is administered subcutaneously. In the case of tubercle, the usual initial dose is one-thousandth of a milligramme of the solid substance (KR), while in the case of staphylococcal and pneumococcal infections, the dose varies from 100,000,000 to 2,000,000,000 organisms. After the inoculation, the index always falls—"negative phase"—but, unless the dose has been excessive, it speedily rises to or above normal. When this has occurred, a second inoculation may be given, the negative phase after the second injection being usually less marked than after the first. On no account should an injection be given during the negative phase, as if this be done the production of opsonins is markedly depressed, and the bodily reaction much lowered. By the introduction of opsonic methods to medicine, an enormous and unexpected extension has been given to vaccine treatment. Formerly, in so far as treatment by tuberculin was a failure, it was so because of the impossibility of regulating the dose. Clinical observation was much too coarse a method, since if an overdose were given the harm was done before it showed itself by clinical signs. In almost every variety of localised infection, the opsonic control of vaccine treatment has proved successful. Ross enumerates some twenty conditions, of which some of the more important are furunculosis, acne, empyema, cystitis, gleet, gonorrhœal arthritis, lupus, tubercular laryngitis, tubercular iritis, tubercular peritonitis. It is not only, however, in therapeutics that the new method is of use; it is of equal value in diagnosis. A normal index, toward any organism, if present on repeated examination, is contra-indicative of the presence of that organism as an infective agent. Some of Wright's experience bearing on this point is almost sensational in its justification, even in the face of apparently certain clinical evidence. The reader who wants at once an intelligible and concise account of the relations of the opsonic theory to diagnosis and therapeutics, cannot do better than consult Ross's paper. We could wish that Wright himself would find time to summarise and systematise his own contributions in a small volume, which would take its proper place as the classic authority. At present his papers are scattered, and hard to obtain, so that many people are at a loss to know where to turn for information.

R.

The Serum Treatment of Dysentery.—Since the definite establishment by Shiga, in 1898, of a bacillus as the specific cause of one form of dysentery, there have been many attempts to produce a serum with protective or curative properties. The most successful worker was Rosenthal, who, by the injection of the serum of horses, immunised by inoculation with dysenteric toxin and live bacilli, reduced the mortality during an epidemic in Moscow from 10 per cent. to 4.5 per cent. His serum was also used with encouraging results during the Russo-Japanese war. Thus, of fifty-nine patients with dysentery treated by Barikin in Manchuria, only one died, and he was moribund when he came under treatment. Vaillard and Dopter have published recently (*Annales de l'Institut Pasteur*, May 25th, 1906), particulars of researches conducted by them at the Pasteur Institute which carry our knowledge of the subject some steps further. In the process of immunising horses they employed alternately live bacilli and toxin in increasing doses. The toxin was obtained by filtering through porcelain a broth culture of the bacilli, which had been kept for twenty days at a temperature of 37° C. The toxicity of the filtrate is such that a fourth of a cubic centimetre, when introduced into the veins, kills a rabbit of two kilograms weight in twelve to sixteen hours. The preventive and curative properties of the serum were tested on rabbits, and it was found that a suitable dose gave complete protection against a lethal dose of both cultures, even when the administration of the latter was delayed for as long as two days. Similarly, if the administration of the serum followed the infection by a period not exceeding twenty-four hours recovery took place. If the period were longer, recovery was not certain. The authors then made use of the serum in the treatment of ninety-six cases of dysentery, only one death resulting. The curative efficacy of the serum showed itself in the almost immediate alleviation of local and general symptoms and in the rapid recovery of the patients treated. The authors believe the following conclusions justified: (1) The serum of horses immunised against the dysentery bacillus possesses anti-microbic and anti-toxic properties; (2) This serum is harmless, even in massive doses, and is a specific treatment for bacillary dysentery; it is without effect in other forms of the disease; (3) Injected in doses which should vary with the gravity of the case, it produces immediate amelioration and rapid cure; (4) Its effects are the more marked the earlier it is given in the course of the disease; (5) The serum ought to be employed without delay in all cases of dysentery which are not known to be amœbic in origin.

Antirabic Vaccinations at the Pasteur Institute.—Viala (*Annales de l'Institut Pasteur*, June 25th, 1906) gives the statistics of the persons treated against hydrophobia during the year 1905 at the Pasteur Institute. Of the 728 persons treated, four died of hydrophobia. Excluding one who died before the treatment was concluded, this gives a mortality of ·41 per cent. The mortality fluctuates greatly from year to year, the highest being ·94 per cent. in 1886, the first year of the Institute, and the lowest ·18 per cent. in 1902. The number of persons treated has shown a fairly steady diminution during the twenty years' existence of the Institute, a diminution accentuated of late years by the establishment of antirabic institutes at Lyons, Marseilles, Bordeaux, Lille, and Montpellier. Of the four persons who died, one had been bitten by an animal whose rabies was established experimentally; two by animals whose rabies was certified by a veterinary surgeon; and one by an animal which was not identified. The particulars of the last case are interesting. The patient, a child of seven, was bitten on December 24th, underwent treatment from December 31st to January 17th, showed symptoms of the disease on April 26th, and died on May 3rd. Three other persons who were bitten by the same animal were treated at the Institute, and did not develop the disease. All the persons in whom hydrophobia developed had been bitten on the hands or face. All those treated were natives of France with the exception of two from England, one from Belgium, and one from Holland. R.

Recent Researches in Leprosy.—Long as leprosy has been known to the world, we are still quite behindhand in our knowledge of its pathology. Although there is no doubt as to the identity of the causal organism, yet it has not up to quite lately been cultivated, nor have animals been inoculated with it successfully. In both these particulars it is probable that a definite advance will soon be made. Nicolle (*Annales de l'Institut Pasteur*, May 25th, 1906) describes certain experiments made on apes, which he thinks justify the following conclusions: (1) Certain of the lower monkeys, in particular the *macacus sinicus*, show a manifest sensitivity toward inoculation with leprous material; (2) experimental leprosy in monkeys requires a long period of incubation; (3) the only successful mode of inoculation is subcutaneous; (4) the receptivity of animals increases when they are subjected to repeated inoculations. Nicolle agrees with Weil in his researches on the cultivation of the leprosy bacillus. Each thinks he has succeeded in obtaining some growth, but only when active young leprous tumours have been employed for inoculating the tubes; attempts at sub-culture have been uniformly negative. R.

Larvæ in the Human Intestine.—Though of common occurrence in cattle, the presence of larvæ in the human intestine is sufficiently rare to render each recorded case of interest. Cattle reports (*British Medical Journal*, July 14th, 1906) what appears to be an authentic case. A young man, æt. 19, complained to him of passing insects in his fæces, and presented for examination large numbers of flattened, fusiform larvæ, about 5mm. in length. These were examined by Professor Cave, of Nottingham, who identified them as of the family *Oestridæ*, or "botflies." One species of this family is parasitic in the gastro-intestinal tracts of horses, and another in the frontal sinuses of sheep. The mode of infection of Cattle's patient remained undiscovered. R.

Actinomycosis with Foreign Body in the Abdominal Wall—Cuff (*British Medical Journal*, July 21st, 1906) publishes an interesting case of actinomycosis of the abdominal wall, in which a piece of straw was discovered. The disease gave rise to a firm fibrous tumour involving the ascending colon and the anterior abdominal wall, and containing several small cavities filled with yellow pus. One of these spaces was much larger than the others, and contained the fragment of straw. Microscopic examination revealed large numbers of filaments of the ray fungus. It appears that the patient had been in the habit of picking his teeth with a straw, and it is almost certain that he swallowed an infected fragment which afterwards traversed the intestinal wall. Such fragments have frequently been found in actinomycotic growths, both in men and animals, especially if the jaws or neck be the seat of the disease, but they are much rarer in abdominal infections. R.

The Formation of Tubo-Ovarian Cysts.—Handley (*British Medical Journal*, June 30th, 1906) reports a case of tubo-ovarian cyst formation which throws a light on the pathology of that condition. Operation was undertaken on account of a fluctuating tumour rising from the pelvis above the umbilicus. It proved to be a tubo-ovarian cyst. The left tube, after running a course of about three inches from the uterus, opened into the cyst by an opening the size of a threepenny bit. The cyst was not uniform in appearance, the inner part being yellowish in colour, and showing the remains of atrophied plicæ. The outer portion was quite smooth of surface and pale in colour. The ovary was not to be found. An examination of the right side furnished the key to the origin of the condition on the left. The outer part of the right tube was distended into a hydrosalpinx, which had burrowed in the ligament until it reached the ovary. Within the ovary, and only separated from the hydrosalpinx by a thin septum, was a single cyst, the size of a small orange. Handley thinks that the condition on the right side was merely an earlier stage in the formation of tubo-ovarian cyst than that on the left. He thinks that in such cases, the ovarian cyst is produced by the pressure of the hydrosalpinx interfering with the ovarian circulation, both lymphatic and venous. Any small existing cyst or corpus luteum may thus give rise to a large cyst if the lymph pressure be sufficiently increased R.

The Relative Physiology of the Uterus and Ovaries.—Bond (*British Medical Journal*, July 21st, 1906) has undertaken a series of experiments in the rabbit to investigate the changes occurring in the ovaries when a part or the whole of the uterus is removed, and, conversely, in the uterus when a part or the whole of the ovaries is removed, and in one ovary when the other is removed. Some twenty-eight experiments were performed. Bond thinks the following conclusions, among others, justified:—(1) The presence of active ovarian tissue is necessary for the preparation of the endometrium as a nidus for fertilised ova; (2) the presence of uterine tissue is not essential to ovarian function; (3) there is some antagonism between the saline secretion of the endometrium and that portion of the ovarian secretion which is concerned in producing changes in the endometrium preparatory to the imbedding of fertilised ova; (4) after removal of a portion of ovarian tissue, the remaining portion undergoes hypertrophy; for this hypertrophy, however, certain stimuli are necessary, viz., repeated copulation or pregnancy; the hypertrophy is similar to that which normally occurs in the ovaries during early pregnancy. R.

Calcification of the Seminal Vesicles.—George (*Journal of the American Medical Association*, July 14th, 1906) publishes a case of complete calcification of the seminal vesicles and partial calcification of one vas deferens. The condition is a rare one, the number of recorded cases being small, and the pathology is still a question of some doubt. George thinks that two quite distinct changes may give rise to the condition—(1) chronic inflammation, as from gonorrhœa, and (2) retrogressive metamorphosis of the muscular coat. R.

Note.—*A Summary will appear each week in the following sequence:*—(1) "*Recent Medical Literature.*" (2) "*Recent Surgical Literature.*" (3) "*Recent Gynæcological and Obstetrical Literature.*" (4) "*The Recent Literature of Physiology and Pathology.*"

NOTICES TO CORRESPONDENTS, &c.

☞ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to 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 proofs.

CONTRIBUTORS are kindly requested to send their communications if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

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.

C. M. B.—The order of the Privy Council containing the present rules of the Central Midwives Board until February 12th, 1907, was issued on July 31st.

HYGEIA.—The assertion that the underground electric is cooler in summer than the above-ground one is disproved by the fact that a large part of the electric energy delivered to the motors on the train is converted into heat. Also the rail friction, the atmospheric resistance, the brake friction, and all absorbtion of energy must re-appear as heat.

DR. G. (Bristol).—The question of fees to medical men called in by midwives has come up many times before the Central Midwives Board, but nothing is yet settled. A speedy decision is necessary, as many of the poorer classes use the services of unqualified women rather than those of a midwife, who is obliged by law to call in a medical man whom they may have to pay.

DR. H. (St. Ives).—It is well to make very thorough enquiry into the disadvantages of a post in the Seychelles. From the accounts of doctors who have lived there, there is a considerable amount of *ennui* even for a studious man, and the common table foods, such as milk and butter are not easily obtainable.

AIX-LES-BAINS.—The laws regulating the reception and habitation of tuberculous patients at Davos are those formulated in 1901. They can be had by writing to the Hotel de Ville, Berne.

BARON MUNCHAUSEN AND THE PHYSICIANS.

A CORRESPONDENT at Liverpool writes us that, having two versions of "The Travels of Dr. Munchausen" which differ materially in some parts, he is anxious to know which contains the correct skit of the College of Physicians? In reply we may mention that the first edition was issued in pamphlet form in 1785, but this we are informed is inaccessible. The second was printed at Oxford in the following year with little or no alteration. Edition after edition appeared subsequently with "sequels" and other alterations, and the original is now unobtainable. If either of those in the possession of our correspondent bears the date 1786, he may take it for granted that he has the correct verson and that it is of considerable value. The original is in the British Museum, and if our correspondent is anxious to compare his with it he can do so; or we can publish a copy of "The Skit" in our next (it is only about twenty lines) if necessary.

MR. A. W. S.—The regulations have been greatly altered of late; it would be safer for you to write to the Registrar for a copy of the new schedule.

MEDICAL INSPECTOR.—The present anxiety about school children is the natural re-action after years of neglect. Certainly it is good to have eyes tested, but the most real psychosis connected with eye-strain is that shown by certain enthusiastic oculists who have become obsessed with the idea that eye-strain forms the back-ground of most pathological conditions.

MEDICO-LEGAL.—There is an Institute of Forensic Medicine and Psychiatry in connection with the Paris School of Medicine. Foreigners who have studied law in a University in their own country may be admitted to the courses. Possibly, as you are going to practise in France, you might be allowed to join.

M. O. H.—Last year the question of exchanging stale loaves for new ones among the poor came up before the London Master Bakers' Protection Society, and they expressed a desire to aid in putting down a system which, seeing the loaves are often kept on open shelves in dirty rooms, cannot fail to be productive of disease.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, AUGUST 8th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—10 a.m. Dr. Ball and Dr. Davis: Diseases of the Throat, Nose, and Ear. Dr. Saunders: Medical Diseases of Children. 2.15 p.m. Medical and Surgical Clinics. 2.30 p.m. X-Rays. Operations.

THURSDAY, AUGUST 9th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—2.15 p.m. Medical and Surgical Clinics. 2.30 p.m. X-Rays. Operations. Mr. Dunn: Diseases of the Eye.

FRIDAY, AUGUST 10th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—10.30 a.m. Dr. Moullin: Gynæcological Operations. 2 p.m. Dr. Ball and Dr. Davis: Diseases of the Throat, Nose, and Ear. 2.15 p.m. Medical and Surgical Clinics. 2.30 p.m. X-Rays. Operations. Dr. Abraham: Diseases of the Skin.

SATURDAY, AUGUST 11th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—10 a.m. Dr. Ball and Dr. Davis: Diseases of the Throat, Nose, and Ear. 2.15 p.m. Medical and Surgical Clinics. 2.30 p.m. X-Rays. Operations.

Vacancies.

Royal Infirmary, Bradford.—Qualified Man to Visit the Home Patients, Assist in seeing Casualties and in the administration of Anæsthetics. Salary £100 per annum, with board and residence in the Infirmary. Applications to Edmund Forster, Secretary.

Sheffield Union Hospital.—Resident Medical Officer. Salary £100 per annum, with apartments, rations, &c. Applications to Albert Edward Booker, Clerk to the Guardians, Union Offices, Westbar, Sheffield.

Worcester County and City Asylum.—Third Assistant Medical Officer. Salary £130 per annum, with board, lodging, and washing. Applications to the Medical Superintendent, Powick, Worcester.

Newcastle-on-Tyne Dispensary.—Visiting Medical Assistant. Salary £160 per annum. Applications to the Honorary Secretary, Joseph Carr, Chartered Accountant, 26 Mosley Street, Newcastle-on-Tyne.

Egyptian Government.—Ministry of Education.—Professor of Midwifery and Gynæcology. Salary £400 a year, with private practice. Applications to the Director, School of Medicine, Cairo, Egypt.

Egyptian Government.—Ministry of Education.—Medical Tutor and Registrar to Kasr-El-Ainy Hospital. Salary £400 a year. No private practice. Applications to the Director, School of Medicine, Cairo, Egypt.

Sherburn (Ancient) Hospital, near Durham.—Medical Officer. Salary £300 per annum, house, coals, &c. Applications to the Master, Sherburn House, near Durham.

Bracebridge Asylum, Lincolnshire.—Senior Assistant Medical Officer. Salary £150 per annum, with furnished apartments, board, attendance, and washing. Applications to the Clerk to the Visitors, W. T. Page, Jun., Esq., Bank Street, Lincoln.

Royal Cornwall Infirmary, Truro.—House Surgeon. Salary £100 per annum, with board and apartments. Applications to J. C. R. Crewes, 4 Paravedras Terrace, Truro.

Stroud General Hospital.—House Surgeon. Salary £100 per annum, with board, lodging, and washing. Applications to the Hon. Secretary at the Hospital, Stroud, Glos.

Southwark Union, London.—Second Assistant Male Medical Officer at the Infirmary, East Dulwich Grove, S.E. Salary £100 per annum, with board, lodging, and washing.—Applications to Howard C. Jones, Clerk, Union Offices, John Street West, Blackfriars Road, S.E.

Liverpool Infectious Diseases Hospital.—Assistant Resident Medical Officer. Salary £120 per annum, with board, washing, and lodging at the Hospital. Applications to the Port Sanitary and Hospitals Committee, Town Clerk, Municipal Offices, Liverpool.

The Royal National Hospital for Consumption for Ireland.—Matron. Salary £75 per annum, with board, &c. Applications to Secretary, 13 South Frederick Street, Dublin.

Fermanagh County Infirmary, Enniskillen.—House Surgeon. Salary £52 per annum. Applications to C. Wilson, Secretary.

Appointments.

CROWE, J. T., L.S.A., Resident Assistant Anæsthetist at St. Mary's Hospital.

CURTIS, WILFRED, L.R.C.P. and S.Edin., L.F.P.S.Glasg., District Medical Officer by the Liskeard (Cornwall) Board of Guardians.

GOODALL, EDWIN, M.D.Lond., B.S., F.R.C.P.Lond., M.R.C.S., Medical Superintendent at the Cardiff City Asylum.

HILL, W. BERTRAM, M.B., Ch.B.Vict., House Surgeon at the Leeds General Infirmary.

KEANE, D. J., M.B., B.Ch., B.A.O., R.U.I., Medical Officer for Enniskillen Union Workhouse, Limerick.

KNIPE, GEORGE W., M.B., B.Ch., B.A.O., R.U.I., L.R.C.P. and S.Edin., L.F.P.S.Glasg., Assistant Medical Officer at the Sick Asylum, Hendon.

LEEDHAM-GREEN, CHARLES, M.B.Birm., F.R.C.S.Eng., Honorary Surgeon to the Queen's Hospital, Birmingham.

MURDOCK, W., M.D.Edin., Certifying Surgeon under the Factory and Workshop Act for the Annan District of the county of Dumfries.

Births.

MUDIE.—On July 30th, at York Lodge, West Norwood, the wife of Arthur Mudie, L.R.C.P.Edin., &c., of a son.

Marriages.

HANNA—ATKEY.—On Aug. 2nd, at Holy Trinity Church, Cowes I. of W., William Hanna, M.A., M.B., Assistant Port Medical Officer, Liverpool, to Sybil Christian, third daughter of the late Joseph Henry Atkey and Mrs. Atkey, Cambridge House, Cowes.

ROCHE—CLERICY.—On July 31st, at the Westminster Catholic Cathedral, Redmon John Roche, M.R.C.S., L.R.C.P., of 18 Bessborough Gardens, S.W., son of the late John Redmond Roche, of Dublin, to Angèle Marie Catherine Clericy, daughter of the late Ange Pierre Jacques Clericy and of Madame Clericy, of Cap Mare, Mentone.

Deaths.

CAMERON.—On Aug. 1st, at 64 Great Portland Street, London, Anne Cameron, widow of the late George Fenton Cameron, M.D., J.P., aged 83 years.

NORCOTT.—On Aug. 4th, at 9 Grosvenor Hill, Wimbledon, William Boyle Norcott, M.R.C.S.Eng., aged 86.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIII. WEDNESDAY, AUGUST 15, 1906. No. 7.

NOTES AND COMMENTS.

Swansea Doctors' Libel Action.

At the Glamorgan Assizes last week was tried an action for libel brought by Dr. H. St. Thomas against Dr. T. D. Davies. The two gentlemen had been in partnership, but a short time ago it was thought better that this should be dissolved, and that each should practise on his own account. An appointment, that of medical officer to the Cwmfelin Steel and Tinplate Company, had been held by the firm, and when it was dissolved, a ballot was taken among the workmen as to which doctor they would have. The voting was in favour of Dr. Thomas, and the disappointed candidate was alleged to be concerned in the getting up of a petition against Dr. Thomas, a petition which was so unfortunately worded that Dr. Thomas felt he must take steps to clear himself in respect of certain statements. The case came on for trial in due course, and twice during the hearing it seems that the two sides nearly came to an agreement; but though the judge tried to accomplish this end, he was unsuccessful. Eventually the jury found for Dr. Thomas, and gave him £50 damages. Judgment for this amount and costs were entered by the judge, but an injunction which Dr. Thomas sought was refused. The case created a good deal of local interest, and we cannot help feeling sorry that the parties failed to adjust the dispute privately, for it is always a pity when members of liberal profession have to drag their differences into the light of day.

Medical Slander Action.

An equally regrettable slander action was tried at Birmingham Assizes between Dr. T. B. Bradley (plaintiff) and Dr. T. K. Williams (defendant). Dr. Williams had bought a practice at Pensnett, near Dudley, which had at one time been carried on by the plaintiff's father, Dr. Bradley himself at the time not being qualified. It seems that when he had passed his exams, Dr. Bradley set up in practice in Pensnett, and was appointed medical officer to several clubs previously held by Dr. Williams, lower rates of remuneration being accepted. A meeting of the district ethical society was held in March, and Dr. Bradley, who was not a member of the society, was asked to attend, and the matter of charges was discussed. The meeting, it appears, adjourned to allow Dr. Bradley time to consider his action, but the next day Dr. Williams' wife wrote a notice and put it up in her husband's waiting-room, saying that Dr. Bradley had been severely censured by the leading doctors in Dudley. Other charges were made against Dr. Williams, but the notice, which was only hung up for an hour, and for which Dr. Williams offered to apologise, was obviously incorrect, and the jury awarded the plaintiff £10 damages. Here again we can only say it is lamentable that these matters should come to the public courts.

Friendly Societies and Consumption.

At the annual sessions of the Foresters' High Court held at King's Lynn last week, Brother Farris, of London, introduced the subject of the provision of sanatoria for the treatment of members and their families. He showed how largely the funds of the society was taxed by the ravages of consumption, and he thought special means should be taken to reduce the claims. Brother Marlow, Parliamentary agent, however, spoke strongly against the efficacy of open-air treatment, he having had personal experience of it in his own family. The meeting was evidently strongly against taking any special measures, and Brother Farris' motion was defeated by a large majority. While it is undoubtedly true that sanatoria are far from being all that could be desired in the treatment of consumption, we think the Friendly Societies would do well to study the German insurance societies' figures. The matter is not one to be lightly decided one way or another.

The Royal Commission on the Poor Laws in Ireland.

It appears to be a trait of the present Irish Government to prefer the politician to the practical expert as a member of the numerous Royal Commissions which have been created with so free a hand. The latest example of this is the exclusion of a representative of the Irish medical profession from the Commission appointed to inquire into the workings of the Poor-Laws. Not only was such a representative excluded when the Commission was originally constituted, but, even when a vacancy occurred owing to the death of the O'Conor Don, a non-medical man was appointed, although the attention of the Chief Secretary had been drawn to the importance of the inclusion of a professional representative. We are glad to see that the Royal College of Physicians of Ireland have now taken the matter up, and that at a meeting held last week it was

decided to approach the Chief Secretary for Ireland, and point out to him the importance of the inclusion of a representative of the medical profession in Ireland amongst the members of the Commission. We trust that Mr. Bryce will accede to the request of the College and of the whole medical profession in Ireland. Should he, on the other hand, allow the policy of the exclusion of the practical expert to continue, he cannot complain if the public at large do not attach the same weight to the findings of the various Commissions that otherwise they might have attached.

The Free Portrait Trick—a Warning.

As other medical men beside ourselves may have received from a Mr. Tanqueray a tempting offer in which he undertakes to supply "absolutely free" a life-sized crayon reproduction of any photograph they may wish to send him, and as they may be led to comply with Mr. Tanqueray's ingenuous request, we think it well to let them know the experience of a member of our staff. On the receipt of Mr. Tanqueray's offer, a photograph was sent by way of experiment. Almost by return of post came back an answer informing the sender that the life-sized crayon was ready, and "was one of the finest crayon portraits it was possible to produce." With this letter came a catalogue of frames, and a promise to send the portrait free if a frame were ordered—the lowest price being one sovereign. If a frame were not ordered, the fortunate owner of the "finest crayon portrait it was possible to produce" was asked kindly to send ten shillings to cover packing and carriage. Our colleague then proceeded to make inquiries as to the cost of transmitting a parcel from Paris by parcels post, and ascertained that three pounds could be sent for one shilling and four pence, and almost double that weight for about sixpence more. He accordingly wrote to the enterprising Mr. Tanqueray and offered to send him this sum *plus* one shilling and eightpence to cover cost of packing. To this letter no answer was received. Our advice to others who may hear from Tanqueray is to obtain some substantial guarantee before giving hostages to fortune.

LEADING ARTICLE.

TEACHING OF HYGIENE AND TEMPERANCE.

THE medical profession in its corporate capacity may congratulate itself upon the fact that during the turmoil of the education controversies it has kept discreetly clear of the religious question, and fastened itself resolutely on to the moral and physical. The former has generated much heat and led to little satisfaction to anybody; the latter has been accepted in principle by everyone, and seems in a fair way to lead to very tangible results. When some three years ago the medical profession sent a deputation to Lord Londonderry to urge the importance of teaching hygiene and temperance in elementary schools, we imagine that most medical men expected one of the usual coldly-sympathetic official answers which harassed Cabinet Ministers find so useful in choking off deputations, and that they were correspondingly pleased when they found a positive welcome awaited their representatives. The work of the deputation, however, did not end with their visit to Whitehall, for on receiving Lord Londonderry's reply, they set to work on a memorandum designed to show how hygiene and temperance could be easily and usefully introduced into the school curriculum. This memorandum, with appendices, has now been issued, and it is deserving of close study not only by medical men themselves, but by educationalists in general. We may say at once that the committee have done their work very well indeed. They have not been prolix and tedious, and they have not been brief and merely suggestive, but within the compass of some thirty pages, they have set out in persuasive language all the principles that should be followed and most of the details by which they may be carried home to pupils. Now, it is obvious in the first place that if hygiene is to be properly taught in schools, to be made, that is, what medical men wish to see it made, namely, an integral part of school life, it is necessary that the teachers themselves should be instructed. Even if there be no official or local difficulties in the way, this education of the teachers will, we fancy, prove a stumbling block for several years. Not that we mean particularly to blame the teachers, but rather that hygiene as understood by scientific men is so wholly foreign, and, indeed, antagonistic, to the deas of the present teachers, that we do not think it likely a generation rooted in the notion of grammar and geography constituting the be-all and end-all of "education," can be expected intelligently and sympathetically to teach hygiene. For what hygiene really connotes is set forth in an admirable essay in the memorandum before us, and therein it is shown not to be the didactic presentation of certain facts ascertained by others, but a living science permeating and guiding all education. In fact, the point of the memorandum really is that the day for the old dogmas has passed away, and what is needed now is scientific teaching based on physiological knowledge, and that the education of the child should be a natural and not an artificial education. If the memorandum is adopted by the Board of Education—and Mr. Birrell has shown himself in educational matters at least as broad-minded as his predecessor—we shall find that in a few years' time the youth of Great Britain may come into that scientific heritage which their fathers have won for them, and which the youth of most European and American States have begun to enjoy already. It is not possible in our present limits to indicate more than very roughly the lines on which the memorandum runs, but we shall be satisfied if we say enough to send our readers to the study of the original document. Beginning with infants, the committee show how at three years of age hygiene may be taught, and, indeed, how at that age nothing else than

hygiene should be taught. They run up a graduated course of lessons for each standard which should send the child of twelve or fourteen out into the world with a sense of decency, a capacity for enjoyment, and an ability to shift for himself that would admirably replace the present half-polished aptitude for vice which passes for "education" in many "centres." We make bold to say that if the Board of Education can be brought to a knowledge of the science which they are constituted to supervise, and if they succeed in inculcating the principle of that science into the authorities whom they control, and, moreover, if they can train teachers intelligently to bring up children according to its canons, we shall hear less talk of racial, industrial and commercial supremacy passing from Britain to its rival competitors among the nations.

NOTES ON CURRENT TOPICS.

A Generous Offer.

We hope that our readers will not fail to notice the important letter from Mr. Henry Sewill which we publish in our correspondence columns this week. Mr. Sewill comes forward with a direct practical suggestion with regard to the preliminary steps that should be taken towards the suppression of quackery. He advocates the collection of facts by inquiry, with a view to the instruction of the public and the Legislature, but he is aware that this cannot be done without considerable expense. In order to show that his enthusiasm in the cause is not an academic one merely, Mr. Sewill makes a generous offer to guarantee the sum of £50, if ninety-nine other people will come forward in the same manner. With such a sum, namely, £5,000, at their backs, a committee should be in a strong position with regard to the collection of evidence. It is hardly possible to believe that with such materials as could then be presented to them, the Government would refuse to appoint a Royal Commission seriously to go into the whole matter.

Motor Car Report.

Motor cars have sprung so suddenly upon the nation, and have reached such a pinnacle of popularity that the country finds itself puzzled as to how to take full advantage of the new method of progression and yet guard itself against the undoubted dangers that accompany it. It is just ten years since the Act which allowed mechanically-driven vehicles to ply the public roads was passed, and it is no exaggeration to say that the result has been to change the whole face of town and country life. To no class has the motor appealed more irresistibly than to the medical profession; a trustworthy car means a saving of time, anxiety, and wear-and-tear that cannot be assessed in pounds, shillings and pence. Moreover, it is impossible to regard medical men entirely as private individuals; they are in a practical sense public servants, and if the motor-car enables them to do their work more efficiently, the public gain in corresponding ratio. The Royal Commission on Motor-Cars which has just reported makes many suggestions, perhaps the chief being the abolition of the speed-limit. The arguments for and against this proposal are complicated, and though no one would wish to be unreasonable, there is a strong and justifiable feeling against reckless driving. Such driving must be put down, speed-limit or no speed-limit. But in the question of pace, we think that special treatment might be given to doctors called to serious cases. Only the other day a doctor was fined because in answer to an urgent summons he technically transgressed the law by driving over twenty miles an hour. A man driving rapidly to a case of postpartum hæmorrhage deserves very different treatment to one careering for pleasure down a London street or whizzing carelessly through a quiet village. A point, too, that must be brought before Parliament when the renewal of the Act is under discussion is the differentiation that should apply to the taxation of cars used for pleasure and those used for business, and here again we claim exceptional treatment for doctors.

Bodie Slander Action.

Mr. Justice Grantham who tried the recent action for slander brought by "Dr." Bodie against Mrs. Hudson, enjoys the distinction of being, we believe, the only judge within living memory whose conduct has been called in question by Parliament, and we certainly never remember any judge to whom both the Prime Minister and the leading newspaper publicly hinted at retirement. It has been said that Mr. Justice Grantham would do well to take his pension as gracefully as he can, for his knack of floundering in morasses of his own making has amounted almost to genius, ever since his political services were rewarded with a judgeship. In the case we have mentioned "Dr." Bodie, music-hall performer and electrical "healer," sued Mrs. Hudson the president of the Leeds Invalid Children's Aid Society, because she had made at a public meeting some statements of an unpleasant nature against himself. It appeared that Mrs. Hudson had been misinformed as to two of the facts she stated, or at any rate she was not able to prove them; but although she was technically in the wrong, the jury, we take it, showed their sympathy with her in the unfortunate position in which she was placed by giving Bodie the smallest possible damages, namely, one farthing. Mr. Justice Grantham, in his summing up, is reported to have said that Bodie had a perfect right to do things his own way, that he undoubtedly did a certain amount of good, that he could not be accused of being a quack, and that it was unfortunate that Mrs. Hudson had treated him (Bodie) with contempt. The only comment we can make on the proceedings is that Mrs. Hudson has our sincere sympathy, and that we are glad to see it already suggested in Leeds that her costs should be defrayed by public subscription.

Industrial Accidents.

THE Workman's Compensation Bill, 1906, which is to be passed in the Autumn Session, has in it many points of interest to medical men, but the one that will raise most discussion is the proposal to include certain defined industrial diseases among "accidents," for which the employer is liable to pay compensation. When introducing the Bill, the Home Secretary mentioned five diseases which he proposed certainly to include, namely, anthrax, lead-poisoning, mercury poisoning, and ankylostomiasis, and he has just appointed a committee—on which we regret we do not see Dr. Oliver's name—to consider what other diseases may fairly be grouped with them. This new view of disease constituting an accident from the legal point of view furnishes an example of how science is gradually leavening the conceptions of the time, for the idea that pneumonia is as much an accident as a fracture, typhoid fever as a sprain, or diphtheria as a cut, is the direct outcome of the more exact pathological knowledge of late years. The latest legal definition of an accident is that given by Lord Macnaghten in 1903, when he said that the word accident within the meaning of statutes was "the popular and ordinary use of the word, as denoting an unlooked for mishap or an untoward event which was not expected or designed." This being now recognised, the Courts have broadened more and more the meaning of the word till it is difficult to see where any line can be drawn. Hernia and anthrax have been held to be accidents, and if they, why not every form of disease? The Court which decided some time ago that a medical man who was inoculated with syphilis while attending a confinement was the victim of "disease" and not of "accident" would, we fancy, now have to alter its decision. The loss of the distinction between the two terms, though it follows scientific and logical lines, may, however, be a serious matter for accident insurance companies.

'The Christian Age" and Inconsistency.

WE have received a copy of *The Christian Age*—which, we are flattered to notice quotes some observations of ours—and our attention is drawn to an article entitled "The Consecrated Doctor," by the Rev. Frank de Witt Talmage, D.D. The article, if not very original or profound, is yet unimpeachable in sentiment, and furnishes an eloquent defence of material medicine and human doctors as opposed to the transcendental ideas of healing that occupy such a large space of some men's minds at the moment. The doctor is drawn sympathetically and referred to with affection, a tone we miss in a good many other papers that come under our notice, and we note with interest that St. Paul's direction to Timothy to take a little wine for his stomach's sake is understood by Dr. Talmage to be a hygienic protest against the impurity of Palestine water. But it strikes us as not a little curious that whereas the article concludes—"All honour, then, to our Christian physicians whose calling and office are thus divinely consecrated," that on the opposite sheet is a full-page advertisement of "Antipon." Those who are unacquainted with this preparation will be pleased to learn that "Antipon" is "The Greatest of Corpulence Cures," and if they read the advertisement they will find that *The Christian Age* gives it a testimonial as a permanent cure for fatness and as being a splendid tonic. What sort of "consecration" does the Editor of *The Christian Age* call this?

Belfast Fever Hospital.

ON August 2nd, the Lord Lieutenant and Lady Aberdeen opened the new Belfast Fever Hospital which has been erected by the Corporation on the Purdysburn estate, adjacent to the City. The proceedings were well organised by Dr. King Kerr, Chairman of the Public Health Committee, and his subordinates, and they passed off successfully in every way. Many difficulties have stood in the way of those who wished Belfast to have such an institution, and it is now nearly ten years since practical steps were taken to move in the matter. However, though the intervening years may have been awkward ones for those in charge of the public health of the city, the hospital has been able to benefit by the experience of others, and to adopt all those improvements which have been made in construction and arrangement of late years. Before the plans were prepared Mr. Mackenzie, C.E., the architect, visited the principal fever hospitals in England and Scotland, and he took great pains that the first municipal hospital of Belfast should be worthy of the town, with the result that for its size the hospital is one of the best designed and equipped of its kind. The small-pox hospital which stands on the same site as the fever hospital, and is still only of a temporary character, is situated well away from the other buildings.

The Dangers of Shrimping.

Now that merry Margate, breezy Brighton, and a hundred other coast-towns are inundated with their annual influx of visitors, all the usual seaside fun will be in full swing; and while their elders are soberly seated round bands and pierrots, the children will be disporting themselves on the shore in the ways they have done since time immemorial. But because customs are old they are not like wine necessarily the better, and a severe hand might with advantage be laid on some seaside recreations. Bathing properly conducted is perhaps the most healthful pleasure that children can have, but paddling is open to great objection, and of all forms of amusement shrimping is perhaps the most dangerous. It is a thoroughly unphysiological performance for children to be sent in the hot sun with perhaps only a cap or sun-bonnet on their heads and their legs absolutely bare. As soon as they enter the water chilling of the feet and contraction of the cutaneous vessels occurs, and with the sun beating on their heads a temporary congestion of the

brain and its membranes naturally follows. When hours are spent wading to and fro with a net to catch shrimps this congestion is liable to lead to such an increase of pressure within the skull as to bring on giddiness, sickness and headache. It is fortunate if the trouble ends there, for long-continued illness and fatal results are not unknown. Shrimping, if undertaken at all, should only be indulged in the latter part of the afternoon, and then only for half an hour or so at a time.

Schoo Anthropometry.

The last places that education reaches, as a rule, are those institutions which were founded for the purpose of educating the youth of the upper and middle classes, namely, our public schools. The archaic traditions of the Universities are from time to time modified slightly by the necessities of life, but the public s chools generally go on their way with a cheerful indifference to the needs of their pupils. Now a new science is springing up in our midst, to which the term "school hygiene" is generally given, but which is imperfectly described thereby. The science we mean is that which regards the youth of both sexes as plastic material, out of w hich the best men and the best women have to be moulded for the benefit of the Empire and of the world, and this science is contemptuously disregarded, for the most part, by those who have the moulding of the material. One day, when the Board School pupil begins to demonstrate his superiority to the public school boy, serious notice may be taken of the science of pedagogy; at the present moment it is in the making. A primary requisite of this science is that it should be furnished with exact data on which to work, and we notice with pleasure that University College School, which is less hide-bound by tradition than its more venerable contemporaries, has adopted a system of anthropometry, with a view to marking the changes in the physique of its pupils from year to year. Dr. J. H. Spenser, the head-master, introduced this system into the Glasgow High School when he held a similar position there, and he has now succeeded in putting it into active operation at University College School. Other head-masters would do well to follow his example.

Opticians and Sight-testing.

The question of sight-testing by opticians is still to the fore, and we have before us an article from the *Daily Telegraph* headed "Oculists and Opticians: the Plea for Freedom." in which the old arguments and, we may add, the old misrepresentations, are again brought forward. Opticians are evidently trying to "educate" public opinion in favour of their claim, and it behoves medical men and medical journals to see that the professional view atta in s equal publicity. Let us say at once that in reply to the "Plea for Freedom" that the protection which medical men urge is the protection of the public against improperly-qualified "sight-testers," and not the protection of medical men as against the public. The stock argument of the opticians is reproduced in the *Daily Telegraph* article, namely that whereas medical advice is needed for disease of the eye, defects of the eye can be treated by opticians. To those who know little or nothing about the delicate mechanism of the eye, such an argument may appear to have some force, but let us assure any who may be inclined to accept it, that medicine recognises no defect in the eye that is not the result of disease or of a congenital weakness or deformity, and that if any of these be not treated by proper measures, of which the adjustment of spectacles is only one, irreparable harm may be done. Hypermetropia and myopia, long or short sight, and all defects of vision, are but the expressions of ophthalmic changes, and as such need radical and not merely symptomatic treatment. The other argument used is that the poor and middle classes cannot afford an ophthalmic surgeon's fees. A statement of this kind is either the result of ignorance or misrepresentation. There are hundreds of general practitioners all over the country who are thoroughly competent to diagnose and treat eye-diseases of every kind and who are doing so every day.

PERSONAL.

The King has been pleased, on the recommendation of the Secretary for Scotland, to appoint Mr. Diarmid Noël Paton, Superintendent of the Laboratory of the Royal College of Physicians, Edinburgh, to be Regius Professor of Physiology in the University of Glasgow, in place of Professor J. G. M'Kendrick, resigned.

Surgeon-General W. L. Gubbins, C.B., has been appointed to Lord Kitchener's staff as principal medical officer of His Majesty's forces in India, in succession to Sir Thomas Gallwey, transferred to Aldershot.

Mdlle. Olga Yakovlev, the doctor who opened a free hospital to the poor in Moscow, and who was exiled to Siberia for withholding the names of wounded revolutionaries under her care, is reported to be dying of consumption.

The name of Dr. John Milsom Rhodes appears amongst those of the new county J.P.'s for Lancashire. We are glad that the honour should have been so worthily bestowed.

Professor Clifford Allbutt has been appointed to serve on the Home Office Committee, which is to decide what industrial diseases shall be regarded as accidents for the purpose of the Workman's Compensation Bill which is to be passed in the autumn.

Dr. Buzzi, the Italian physician in attendance on King Charles of Roumania, was lunching with his Majesty at Sinaia on Tuesday, when he had a sudden attack of paralysis. King Charles was much affected.

Dr. Thomas Moorhead, J.P., Cootehill, has been elected President of the Irish Poor-law Officers' Association, and Dr. R. M. Blake, J.P., has been re-elected to the office of Vice-President.

The passengers of the "Empress of Britain," which sailed from Liverpool on August 10th, included Sir William Broadbent and fifty other medical gentlemen bound for the British Medical Association Congress in Canada.

A CLINICAL LECTURE
ON THE
DISEASES OF THE SKIN CAUSED BY INSECTS.

By JONATHAN HUTCHINSON, LL.D.Oxon., Hon.M.D.Dub., F.R.C.S., F.R.S.,
Consulting Surgeon to the London Hospital, the Hospital for Diseases of the Skin and Royal London Ophthalmic Hospital.

GENTLEMEN,—To-day I am going to deal with, apparently, a very simple subject, but, I believe, notwithstanding its apparent simplicity, a very important one—viz., the extent to which animal parasites may attack the human skin and produce skin disease; and to claim that a great number of those diseases, which have received quite special names, and concerning which we have sought out special symptoms, may be referred to the bites of insects. I will commence by showing you a series of drawings, in order that from them you may realise what it is possible for insects to do to the human skin.

Here (diagram shown) is a very formidable-looking thing—a slough and a considerable amount of ecchymosis on the hand of an adult. There are three or four other places on the other hand, not nearly so formidable looking, but representing the same thing at a later stage. The cause of that is known. These hands are the hands of a surgeon who knew the whole history of his case, and who killed the fly which had bitten him and had produced that condition. Unfortunately, he did not keep the fly, but there is no reason to think that these sores on his hand were the result of any dead material or any organic organism in his blood. The bite, I believe, was that of an ordinary gadfly. One peculiarity about the bite of a gadfly is, that if you allow it to subside it goes away in about a week and leaves a papilla which itches for a day or two and then disappears, but at the end of a fortnight recurs. Scabies may be cured and then come back for a time. This does not at all prove that the poison of the insect is still present in the skin; it simply shows that, with regard to these skin diseases, there is a liability to recrudescence.

Here is a drawing (diagram shown) that would puzzle most people for a diagnosis. You see the result not of an insect prick, but of mechanical irritation. You see there a pigmented skin, with a superficial scar, covered with a lot of little scars, this condition having arisen from mechanical irritation caused by the prick of a syringe for injecting morphia.

This drawing (diagram shown) illustrates what is possible in the form of mixed results produced by the action of pyogenic organisms, secondary to the irritation of insects. This is a disease of the skin known as impetigo which, in this particular case, began with irritation produced by lice. Then the part got infected with pyogenic organisms, and, as a result, the disease ran a somewhat different course from what it would otherwise have done.

In this (diagram shown) you will notice little blue patches scattered on the inside of the thighs of an adult man. You will see nits of lice on the hairs of the pubes. That is an eruption acknowledged to be the result of the presence of the pediculus pubis on the skin.

Here is another illustration of skin disease (diagram shown), due to the presence of lice on the pubes. The lice on the pubes do not travel, but remain on the hair.

Here are two diagrams (shown) illustrating the result of bites of insects on the naked skin. These blue patches are a somewhat different eruption to that produced by the pediculus pubis. We in England have comparatively little of that kind of eruption.

This next portrait shows the result of long-continued, repeatedly-recurring pricks of the body louse, pediculus vestimentorum. This is known as vagabond's skin, produced by having lice constantly upon it, and which is characterised by pigmentation and a scar all over.

(a) Lecture delivered at the London Hospital, July 3rd, 1906.

This is another example (diagram shown) of pigmentation from body lice. You will notice scattered blotches all over the thigh. In all cases in which we suspect insect pricks we look to the centre of the papilla, and if there is a centre displaying a little depression, or a minute scar, it is very suspicious of prick from some insect.

Here is an illustration (diagram shown) of what the flea can do. There you see an eruption occurring on the arm of a delicate, fair-complexioned child, and entirely due to fleas.

This diagram (shown) represents a case which I had under my own observation, and I believe the flea that caused these bullæ was subsequently caught and killed. These bullæ are the remains of flea bites, and it is one of the characteristics of eruptions due to parasite bites that you are able to see them in various stages. These bullæ are the result of scratches which leave scars containing blood. What I particularly want to insist upon is that the flea can produce bullæ of large size. This case was that of a child, one of a family of three. His brother and sister were not especially liable to flea bites. It is an interesting fact that some persons appear exceedingly prone to get fleas, whilst others never seem to be troubled with them. This child's grandmother and some of her cousins were remarkably subject to attacks by fleas. Another interesting point is that an eruption caused by flea bites, in children, is often attended by severe febrile disturbance—high temperature and sickness. I remember a family of children, two of whom were in bed for days, not infrequently, with febrile illness. I was in correspondence some years ago, repeatedly with some parents living in Lancashire who consulted me about an eruption from which their child suffered, and which no one could understand. The child would be in good health, and then out would come a severe eruption, attended with sickness and temperature for some time. This occurred every now and again. Several times an appointment was made for the child to be brought to me, but the appointment could not be kept because the child was too ill to come. Finally, however, I saw the child, and found that what it was suffering from was nothing but the result of flea bites. It then had a very severe bullous eruption, attended by febrile disturbance. This case illustrates the severity of a process which may arise from the ordinary prick of a flea, or some other insect, with intent to suck blood.

I now come to ground which is disputable, and I claim that various forms of the disease known as urticaria are very often due to flea bites. Prurigo urticaris, lichen urticatus, urticaria perstans, and urticaria pigmentosa are the result of nothing but flea bites or bug bites. This diagram (shown) represents what so high an authority as Dr. Fox described as lichen urticaris, which, he contends, is a definite disease of itself. My contention is that it is always due to flea bites.

This is an exceedingly valuable portrait (shown) illustrating a supposed case of prurigo urticaris. The patient was a country child who had been quite free from eruption until brought up to London. The child slept one night in London, and next morning was covered with this eruption that you see. Dr. Fox said it was London milk that did it. I think it was the London flea. If you will examine the eruption, I think you will conclude that I am very much justified in holding that opinion. In the centre of every one of these erythematous patches there is a prick, and in

many places the erythema is fading away. Is it at all probable that in a healthy child, brought up to London, a change of diet would, in twelve hours, bring out an eruption like that? The child was made feverish by the eruption, and there is conclusive evidence, borne out by those other representations of skin eruptions which I have shown you, that this particular eruption was due to flea bites. In describing the characteristic bullæ of prurigo urticaris, Dr. Fox mentions that they have little centres. I myself cannot explain the centre of an eruption as due to some article of diet, but I can explain it as due to prick.

Lichen urticatus is a very common eruption, and most frequently occurs across the loins. This disease is especially common on the buttocks and across the loins in children. Those positions are a kind of harbour for lichen urticatus. There is another disease called purpura urticans, in which the eruption is very like the wheal of urticaria, and liable also to hæmorrhage. These two skin affections are caused by the bites of fleas. The bites of fleas frequently produce wheals exactly like urticaria. Before I first came up to London I did not know what a flea bite was, but after I came I thought I had become a subject of urticaria, until I discovered that the eruption on my skin, from which I repeatedly suffered, was due to flea bites. I meet with many persons who have an eruption and do not know in the least what is the cause. I remember a lawyer telling me that at a certain place he always got urticaria. He told me the name of the place, and I have not the slightest doubt that his urticaria was the result of flea bites. The wheal of urticaria gets its name from being like wheals produced by the sting of the nettle. The stings of insects also produce wheals. These wheals generally have a centre, and every now and then that centre will be hæmorrhagic, and then the person affected will get purpura urticans. Here is (in diagram shown) a distinct centre a little discoloured, as the result of a little hæmorrhage into it. Here is another centre which, I claim, is due to a prick. That is an illustration of purpura urticans. Is it an unreasonable suggestion that it is the result of flea bites?

This diagram (shown) illustrates a skin affection known as lentigo lentiginis, or freckles on the nates. This is not an uncommon condition, and I believe it is a remote result of insect pricks. Here (diagram shown) is a typical prurigo. If those other conditions, of which I have already shown you illustrations, are due to insect bites, this also appears to me to have resulted from a similar cause.

Here is an illustration (diagram shown) of an eruption on the buttocks. The buttocks are very apt to be attacked. It is a blotchy eruption, and you cannot see the central points so well, as they are in a fading condition. This eruption puzzled those who were called upon to treat it, but I claim that it is due to bug bites. Between bug bites and flea bites the distinction is very considerable. Flea bites produce an eruption much more like urticaria, the part affected presenting a marked state of congestion and a central puncture. On the other hand, bug bites produce an irregular area of dusky congestion, with nothing exactly like the urticarial wheal. Bug bites are very much more infrequent than flea bites. The bug is very apt to attack the face; it prefers the face, or the scalp, especially of bald-headed men. The bug bite, unlike that of the flea, does not itch intolerably, and very often not at all. A man may have disfiguring blotches on his face, the result of bug bites, without being aware of the fact, until he has made the discovery through the looking-glass. That is very common with bug bites. If an eruption occur on the face, and especially on the bald scalp, then I should suspect bugs much more than fleas as having been the cause. If the eruption is dusky in colour, that fact should confirm your suspicion.

We come next to the consideration of the disease which goes under the name of urticaria pigmentosa. My friend, Mr. Nettle, whose writings are well-known, was the first to describe cases of this kind; he described them at the Hospital for Skin Diseases. Urticaria pigmentosa is now a well-recognised disease, and in this diagram (shown) we have a good illustration of it. The disease lasts for a long time. Here is another illustration (diagram shown) of urticaria pigmentosa in a child. The eruption has a tendency to persist and become pigmented, more or less. This (diagram shown) is another representation of the disease in a boy. The blotchy character of the spots is well shown. In urticaria pigmentosa the face only escapes. Here is another example (diagram shown). You will notice a little hæmorrhage in some of the spots; they represent various stages in the disease. I think you would suspect that this eruption was due to insect bites.

Here is a picture (shown) illustrating the early stage of what is called urticaria papulosa, a skin disease which is also, I maintain, due to flea bites. The history of this particular case would, in all probability, show that flea bites had been the real cause of the eruption. Urticaria pigmentosa almost always begins in childhood though not in early infancy. The child is liable to recurring eruptions, crops of which come and go. When the eruption disappears minute quantities of blood are left behind, which form permanent papules, and these subsequently pigment. The disease persists till nearly adult life, and then the patients almost all get well. We know that liability to attacks by insects diminish as the patient's skin advances in age. The manner in which the eruption of urticaria pigmentosa is arranged, in cases of insect bites, is very important for diagnosis. You will never see any circular patches; the eruption is always irregular, it is never distributed with perfect bilateral symmetry. Complete bilateral symmetry implies blood disease. The irregular eruption of urticaria pigmentosa I have been accustomed to describe as presenting an appearance like the constellations in the sky. Insect pricks run, so to speak, in a straight line, then they run off in different directions, and the area affected presents any shape excepting that of an eclipse or circle. This irregularity and constellation-like arrangement, either in lines or curves and never in accurate circles, is a very important point in connection with diagnosis. The fact of the eruption becoming pigmented is due, I take it, to a peculiarity in the individual.

A very interesting point, confirmatory of my suggestion that urticaria pigmentosa is due to insect pricks, occurs in connection with a case published by Dr. Crocker. He states that a child was taken into University College Hospital, in order that the medical men there might see the initial lesion. But the initial lesion would not come, simply because its cause was not there, and they let the child go home again.

This diagram (shown) represents a case of infantile ecthyma, a disease which is due to pyogenic organisms, but which may easily be developed by scratching eruptions that begin with insect pricks. I would suggest that this was a case of infantile ecthyma, secondary to ordinary flea bites.

Here is a very old drawing (shown) which passes under the name of urticaria pelicalis. Here there has been very considerable extravasation of blood, from thrombosis. There is a good deal of blood staining in these four patches. Our forefathers did not have accurate representations copied from one stage of skin disease in a patient; they often represented different stages taken at different times. That, I would suggest, has been done in this case. Here is another illustration of the same disease in a boy. When I first saw him I noticed two dusky places, with extravasation on his calves. He was in good health. I jumped to the conclusion that these extravasated places had really been due to insect bites. The child had been exposed to the risk of being bitten by insects. This case was evidently an aggravated condition of insect pricks, the aggravation being due partly to the position of the affected places on the boy's legs. This diagram (shown) represents a later stage—a week or ten days later—of the disease, in the same case.

You see here (diagram shown) an illustration of what is known as lichen urticatus. In this case the disease

has become gangrenous, and I claim that it is the result of insect bites. In no other case have I seen such a serious condition due to the bites of insects.

This case of lichen urticatus (diagram shown) has probably been due to the stings of gnats, or of mosquitoes, just such as frequently occur in India.

Here is another illustration (shown) of the same disease which, in this case, has been partly due to scratching, secondary to insect bites.

That is my contention, then, with respect to these various diseases—that before we give learned names and attribute specificity to them, we ought very carefully to examine the evidence as to whether they may not be due to some very simple cause, and that cause an external one. I think I have given you proof that a great many of these skin diseases are due to insect poison. I have also shown you some which so closely resemble those others as to warrant an inference that they are really all due to the same cause.

It is only right to state what are the tests to which the assertion which I have made can be brought. It can be brought to several very useful tests. If, for instance, you suspect that a case of eruption is due to the bites of insects, you should first observe whether the eruption is symmetrical, and then whether it occurs in successive crops. That is extremely important. Cases of urticaria pigmentosa always occur in that way. Then, again, you should ask the nurse whether the eruption makes its appearance at night or during the day. If she says that the child always gets fresh spots during the night, that is very important, because we know that these insects bite chiefly during the night. Of course, people may come into contact with dogs and other animals and in that way get insects which may bite them during the day. But still, the general statement is that the eruption occurs in crops, and these crops occur during the night. Then, if the nurse tells you that the fresh spots do not occur on both sides, but are localised, that is helpful evidence. If the eruption is large, it may be on both sides, but if the fresh spots are always local, that is a very useful symptom.

You ought not to allow the fact that the child is ill or feverish to be any reason whatever against the eruption being due to insect bites.

The last test will be to take the child away from its surroundings, to take it to the hospital, for instance, where it will be under cleanly conditions, and then observe whether the eruption recurs. If the eruption is a seaside eruption, it is very suspicious. A child may get an eruption when visiting a farmhouse; he may go into the henhouse and may there be stung by a particular insect, and if he is bitten by it, there is a possibility of his getting an eruption which may mislead anyone. These, then, are the particular tests which I am quite willing to submit.

I would impress upon you the importance of making your diagnosis carefully, and if you are satisfied that the eruption is due to insect bites then use your insect powder and let the child's skin be anointed with a little lotion destructive to insects. But do not tell the nurse the cause of the eruption, or else you will lose your patient. The fact that the child has fleas may not be the result of carelessness in the least, but if you mention that cause to the parents they will resent it. I remember one case which I had, and the mother said, "What is it?" "I will not tell you. I am sure, if I tell you, you will not believe it." "Oh, yes, I will believe anything you tell me." "Well, it is all due to flea bites." "No, I'm quite sure it's not!"

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week's issue will be by Jonathan Hutchinson, LL.D., Oxon. and Cantab., Hon. M.D. Dub., F.R.C.S. Eng., F.R.S, Consulting Surgeon to the London Hospital, the Hospital for Diseases of the Skin and the Royal London Ophthalmic Hospital on "Tuberculosis and Diseases of the Skin," delivered at the London Hospital, June 26th, 1906.*

ORIGINAL PAPERS.

BRADYCARDIA.

By JOHN HAY, M.D., M.R.C.P.,

Physician, Stanley Hospital, Liverpool; Physician, Hospital for Consumption and Diseases of the Chest, Liverpool.

THERE is a form of bradycardia termed "paroxysmal" or "intermittent." Two varieties are described:—

1. In which the pulse is permanently infrequent, and there are sudden accesses of greatly diminished frequency.

2. Where the pulse is of normal frequency between the attacks.

The case which I shall now relate belongs to the first variety. The following are the important points to be noted in reference to it —

1. Marked bradycardia, the pulse frequency ranging from 17 to 30 per minute—*à pouls lent permanent.*

2. Transient loss of consciousness, associated with cessation of the pulse at the wrist.

3. Auricular contractions, occurring twice or thrice as frequently as the ventricular—the cause of the bradycardia being "heart block."

4. An enormous heart; the autopsy revealing no cause for the hypertrophy and dilatation.

I give a brief résumé of the case.

R. M., æt. 26. Healthy till May, 1898, when he suddenly lost consciousness. Some time later he was admitted to the Royal Infirmary, under the care of Sir James Barr, to whom with Dr. Raw I am indebted for permission to publish the case. On admission he complained of breathlessness on exertion, and attacks of unconsciousness.

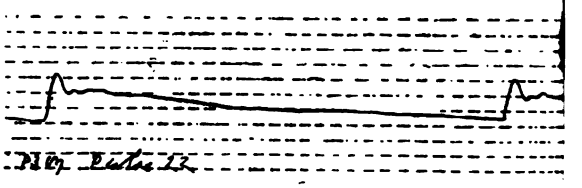

FIG. 1.
Pulse tracing taken by Sir James Barr. Rate, 20 per minute.

On January 8th, 1900, he entered Mill Road Infirmary suffering from extreme cardiac failure. He died on January 15th, 1900. When he was in the Royal Infirmary I noted the following points:—

1. The apex beat was situated outside the nipple line, slow, heaving, and forcible in character, 20 beats per minute.

2. Pulsations or small beats, 50 or 60 per minute, occurred regularly over the 3rd left intercostal space, just to the left of the sternum.

3. Synchronous pulsations were observed in the veins of the neck.

4. Definite systolic retraction in 3rd, 4th, and 5th left intercostal spaces.

5. Cardiac dulness (deep) extended 7 inches to the left, 2 inches to the right of the middle line.

6. Systolic murmur at all areas, loudest and harshest over conus of the right ventricle. It was conducted to the left, and was heard along the vertebral border of the scapula.

7. No sounds were audible accompanying the small pulsations above mentioned.

8. Pulse varied from 17 to 30 per minute.

Fig. 1 is a pulse tracing taken from this patient.

The cardiogram (Fig. 2) demonstrates the slow rhythm of the ventricle, and the more frequent rhythm of the auricles. When the contraction of the auricle coincides with that of the ventricle, it is masked by the record of the ventricular contractions. The waves in the venous pulse tracing are seen to be synchronous with those of the cardiogram. The tracings show, therefore, the two independent rhythms, auricular and ventricular.

The pulsations visible over the conus of the right ventricle were due, in my opinion, to the strong right auricle forcing blood through into the right ventricle, the ventricle being in disastole and permitting the impact of blood to make itself evident by a slight movement of the chest wall over the conus.

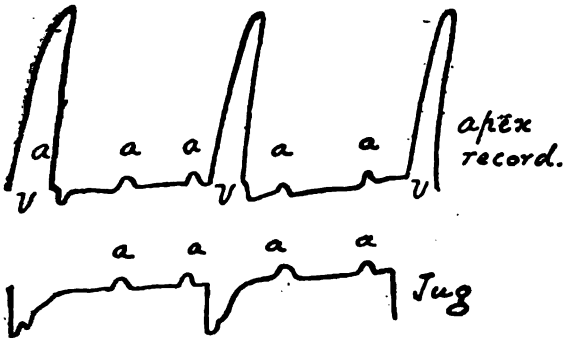

Fig. 2.

Shows that the auricles have a rhythm independent of and different from that of the ventricles.

a=movement of the lever due to contraction of the auricles.

v=movement of the lever due to contraction of the ventricles.

The upper tracing is a cardiogram, the lower is a record of the pulsations in the jugular vein.

Later, when admitted to Mill Road, it was noticed that the cardiac dulness (deep) had increased to the right by one inch; that the only murmurs persisting were a marked tricuspid regurgitant, and a faint mitral regurgitant, and that the frequency of the pulse had reached 40 to 80 per minute.

The autopsy, to my astonishment, gave us little assistance. The area of deep cardiac dulness as previously determined was mapped out on the chest, and its correctness proved by the insertion of long needles at right angles to the surface. To the right the needle was found to have entered the pericardial sac without touching the heart; at the apex the needle just entered the edge of the left ventricle, thus demonstrating that the deep cardiac dulness as elicited ante mortem was correct. Pericardium normal. The heart weighed 29 ounces, showing marked hypertrophy and dilatation. Valves all translucent, and normal in appearance. Tricuspid valve very incompetent. Mitral valve also incompetent. Liver "nutmeg." Kidneys weighed 15 ounces, and on microscopical examination were found to be normal except for signs of back pressure.

Some weeks ago I sent the heart to Professor Arthur Keith, of the London Hospital, for his opinion. With exceptional kindness he has drawn a diagram showing the condition he found and more particularly that of the auriculo-ventricular junction. I reproduce the diagram (Fig. 3).

From the report with which he favoured me I quote the following:—

"The two marked changes in your specimen (besides the hypertrophy and dilatation of the chambers) are: (1) Stretching of the auricular canal (the portion normally within the auriculo-ventricular groove); (2) Separation, or rather attenuation, of the bond between the bases of the valves (tricuspid) and base of the ventricle."

Remarks.—This is an undoubted example of "heart block."

Normally the stimulus to contraction is initiated in the remains of the sinus venosus, consisting of the musculature at the mouth of the great veins, and adjoining portion of the right auricle.

The wave of contraction spreads over the auricle and through the auricular canal on to the ventricle "with varying speed, quickest over the tissue, which has become modified so as to approach more nearly in its properties to ordinary striated muscle, namely, the reticulated bulged portion of the auricle and ventricle; more slowly over those parts which retain a more embryonic character, namely, the auriculo-ventricular muscular ring and the bulbus arteriosus."

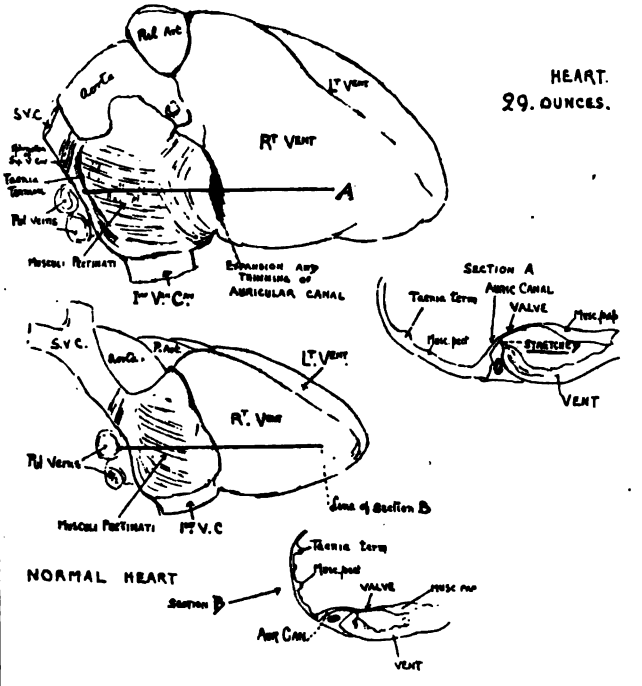

Fig. 3.

Diagram drawn by Professor Keith. It compares the heart of the patient with a normal heart, and demonstrates the condition present at the auricular canal. (Drawn to scale.)

Normally, the ventricle responds to a stimulus spreading down to it from the auricle; if by any means the ventricle is cut off from this normal periodic stimulus, it tends to initiate its own stimulus, and to take on a rhythm different from and independent of the auricle. Gaskell demonstrated this in the frog's heart by ligaturing the auriculo-ventricular groove so that no stimulus could cross from auricle to ventricle. The term "heart block" is applied to this condition.

A heart in which the auricle dominates the rhythm as a rule, beats with normal frequency. When the stimulus for ventricular action arises in the ventricle itself there is a slow rhythm. The result of "heart block" is therefore bradycardia. Such a condition we find in this case; the block in all probability takes place at the attenuated portion of the ventricular wall situated at the base of the ventricle, at its junction with the auricular canal. This attenuation, described by Keith, could not fail to involve the auriculo-ventricular bundle of His, the only muscular connection between the auricles and ventricular and thus the "pathway of the stimulus to contraction" would be damaged.

An interesting question arises as to the cause of the great hypertrophy and dilatation. It is too great to be satisfactorily accounted for by the strain of work. It is not due to chronic nephritis. There is no sclerosis of the valves. The incompetency of the mitral and tricuspid valves must be in some degree responsible, but it pertains rather to the later stages than to the period of comparative compensation, when, as we have already noted, there was a transverse cardiac dulness of 9 inches.

I suggest the following explanation. Since, during each ventricular diastole, the auricles contracted twice or thrice, the resulting condition in the ventricles would

be one of over-distension, and they would during their systole have an excessive amount of blood to deal with. The strain on the ventricular walls due to the forcible pumping of blood by the auricles would produce dilatation, and the large volume of blood to be dealt with would necessitate hypertrophy.

The discussion of this case would be incomplete if it did not include a brief reference to the "attacks of unconsciousness" of which he complained. Twice on March 23rd it was noted that during an attack of dizziness his pulse became imperceptible, returning gradually to its normal rate of 20 per minute. I believe that this cessation of ventricular systole explains these attacks of unconsciousness, and brings this case into line with the more pronounced forms of "Adams-Stokes syndrome."

We may conclude, then, that in the case I have described the bradycardia was due to a condition of heart block—so complete that the auricles and ventricles beat independently of each other.

There are other cases, however, in which the block in the auriculo-ventricular bundle of His is not complete, and where the ventricles respond to every second contraction of the auricles, or even to every third or fourth contraction.

Quite recently I had the good fortune to meet with such a case in which the bradycardia was caused by a severe depression of conductivity, the ventricle failing to respond to every second contraction of the auricle. The patient I refer to is æt. 62. His occupation up to the present illness was that of baker. This entailed the carrying of heavy loads up and down stairs. He denied syphilis or alcoholic excess. The present illness began three years ago with a sudden loss of consciousness. Since then he has occasionally suffered from "mazy bouts." The doctor in attendance told me that when he first saw him eighteen months ago he noticed that the pulse was 20 per minute; there was then some bronchitis, with considerable dyspnœa, The extremities were cold, but there was no cyanosis or œdema.

Since that time his pulse had remained persistently infrequent and the bradycardia probably dates from then.

I was surprised at the healthy appearance presented by the man. He had good colour and was well nourished but there were signs of deficient aeration of the blood in the hands, which were very cold, and, according to the patient, became livid and numb on the slightest exposure. He felt perfectly well, with the exception of great dyspnœa on exertion. His area of cardiac response was limited. His chest was distinctly emphysematous. The radial and temporal arteries were uniformly thickened and tortuous. His pulse rate was 32 per minute—the pulse regular in force and frequency, of large volume and good tension. I noticed two beats in the neck to each radial pulse and tracings demonstrated this fact. On analysing the records, it is seen that the auricular beats occur at regular intervals and that every other beat is followed by the carotid pulse. It is almost impossible to record the venous pulse in the neck without at the same time recording the carotid. This is rather an advantage than otherwise, as it gives us a fixed point in the analysis of the tracing in the record of the jugular vein; the distance from the beginning of the contraction of the auricle to the first appearance of the carotid beat corresponds roughly to the time between the auricular and ventricular contraction. This interval is called the a-c interval, and is normally about 1-5th of a second in duration.

Where, however, there is depression of conductivity, and the stimulus finds greater difficulty in passing from auricle to ventricle the a-c interval is lengthened.

It is so here. Instead of being 1-5th of a second, it is 2-5ths.

On analysing the tracing we find first an auricular contraction 'a^1' followed by the carotid pulse 'c,' and note the a-c interval as double the normal length. Then we meet with another wave due 'a^2' to a second contraction of the auricle, but this time there is no sign of ventricular response. The stimulus has not been

FIG. 4.

E = the sphygmic period, or period of ventricular systole, as shown in the radial pulse, and as shown in the tracing from the jugular.
a^1 and a^2 = Auricular waves in the tracing.
c = Carotid pulse recorded simultaneously with the venous pulse.

able to reach the ventricle. This sequence is repeated without variation in all the tracings.

To demonstrate the action of the heart when Fig. 4 was taken, I have constructed the diagram Fig. 5. It is built on the plan adopted by Wenckebach and Mackenzie. The down strokes in the upper division, AS represent the auricular systoles and correspond with the waves "A" in Fig 4, while the down strokes in the lower division, VS, represent the ventricular systoles and correspond to the radial and carotid pulses in Fig. 4. The short thick lines connecting these down strokes represent the passage of the stimulus through the fibres joining auricles and ventricles. In this case they are 2-5ths of a second in duration—that is, double the normal length. The absence of this line indicates that the stimulus has failed to pass these fibres, and hence a ventricular systole drops out.

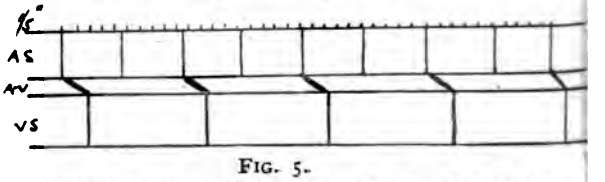

FIG. 5.

Diagram constructed to show the action of the heart when Fig. 4 was taken.

The heart is little, if at all, enlarged. The deep cardiac dulness measures 1½ in. to the right, 4 in. to the left of the middle line. It was difficult to hear the heart sounds at the base owing to emphysema. At the apex I made out a wheezy systolic bruit, followed by a clear second sound, and then, during the diastole of the ventricle, and synchronous with the extra pulsation in the neck, I heard a short whiffing murmur due, I believe, to the auricular systole forcing blood into the partially filled ventricles.

THE last stage of a Swansea Valley controversy took place on July 31st, when a Local Government Board inquiry was held at Pontardawe into the circumstances of the re-appointment of Dr. Griffiths as medical officer of health, after a previous decision of the council not to reappoint him.

AMONGST those present at the annual dinner of the Medico-Psychological Association of Great Britain were the Bishop of St. Albans, Lord Monkswell, Sir Ralph Knox, Sir Owen Roberts, Mr. Justice Walton, Canon Swallow, and Sir Edwin Cornwall, M.P.

CEREBRO-SPINAL MENINGITIS.*

By CARLOS FRANCA, M.D.,
Of the Faculty of Medicine, Lisbon.

Of the many varieties of meningitis, epidemic cerebro-spinal meningitis is the only one that constitutes a well-defined morbid entity with its own peculiar symptomatology, its pathological anatomy and specific micro-organism. All the other forms are meningeal localisations, either of some common bacillus or of the infective germs of other diseases.

Whatever organism happens to obtain a foothold in the meninges, it invariably gives rise to reactional inflammation manifested externally by a symptomatology which does not necessarily vary with the particular agent to which it owes its origin. True, there are certain slight differences to be noted between the other forms of meningitis, but the general picture is the same whether we have to deal with a case of tuberculous meningitis, epidemic cerebro-spinal meningitis, a pneumococcal or a streptococcal meningitis.

In epidemic cerebro-spinal meningitis several clinical types may be observed. The commonest form is that in which the onset of the disease is sudden, with headache, vomiting, fever and sometimes convulsions. Then, on the second day, we get stiffness of the neck or opisthotonos, Kernig's sign, photophobia, and delirium. These symptoms persist for several days, and then there supervenes a period of remission of the fever. The disease runs on for two or three weeks, with repeated exacerbations of the headache and fever until the temperature subsides by lysis. This marks the commencement of convalescence, and is perforce somewhat protracted on account of the damage to which the meninges have been subjected.

Another clinical form is the malignant variety, in which the disease supervenes with crushing violence; is associated with hæmorrhagic changes in the skin, and in which the general conditions rapidly go from bad to worse. In this form we are early confronted with grave disturbances of respiration and circulation, the patient falls into a comatose state and succumbs in from twenty-four to thirty-six hours.

Lastly, there are chronic forms, relapsing forms, in which the patient appears to be entering upon convalescence, but the disease persists for several months with alternating phases of remission and exacerbation. Throughout the whole duration of the affection, Weishselbaum's diplococcus is found in the cerebro-spinal fluid.

In tuberculous meningitis the clinical aspect also varies a great deal in certain cases. Thus, in infants at the breast, the prodromal period is often wanting, and, on the contrary, the onset may be sudden, with convulsions or hemiplegia, followed by a semi-comatose state, which culminates in death in the course of four or five days. In adults and young people the disease may commence with some solitary symptom which persists alone for a long time. In such case, as soon as the other symptoms present themselves, the disease usually runs a rapid course.

Although the progress of the disease sometimes allows of our establishing a differential diagnosis between tuberculous meningitis and other forms of the disease, this is impossible in the vast majority of cases, unless we have recourse to lumbar puncture. By no other means can we scientifically determine the particular variety of meningitis under observation.

In marked contrast with the pronounced poverty of the normal cerebro-spinal fluid in figured elements, meningitis is always associated with a comparatively well-marked leucocytosis. The most interesting feature of this leucocytosis is the extreme variety of the cellular elements present, for, according to the case, this or that micro-organism tends to predominate.

In epidemic cerebro-spinal meningitis the cerebro-spinal fluid is, to begin with, rich in polynuclear leucocytes, and polynucleosis is the most marked feature of the acute stage of the meningitic process. Later, if the disease persists, it is not unusual to witness a change in the histological character of the fluid. The cells with polymorphous nuclei become fewer and give place to lymphocytes and mononuclear cells. In such cases, when there is an exacerbation of the morbid process, a further augmentation in the proportion of polynuclear cells takes place.

Cytological examination of the cerebro-spinal fluid in cases of tuberculous meningitis gives very different results. Here lymphocytosis predominates, while polynuclear cells are only present in comparatively small numbers.

We have bacteriologically examined some 271 cases of epidemic meningitis, and in every instance we have found Weishselbaum's *micrococcus intracellularis*. It is worthy of note that in such an extensive epidemic as that of Lisbon, we only met with three cases in which the meningitis was due to any other organism. In one instance it was the pneumococcus, once the streptococcus and once the staphylococcus.

What may be termed the classical treatment of meningitis consists in the use of baths at a temperature of 104 °F., but the painful contraction of the neck muscles renders the bath treatment very distressing. Lumbar puncture, on the other hand, is well borne, and determines a tangible improvement. In the first place it diminishes the pressure of the cerebro-spinal fluid, and in the second place it is the means of getting rid of a large number of microbes with their toxic products. It is therefore the most rational mode of treating epidemic meningitis, and the reason why certain authorities have failed to develop any enthusiasm about this mode of treatment is that they have not employed it in the proper way. In order that the puncture may have a well-marked therapeutical action, a large quantity of liquid must be withdrawn, and the intervention should take place as soon as the symptoms point to a heightening of tension. If we proceed in this way, making one or even several punctures daily, in the early stage, we obtain very encouraging results.

Epidemic meningitis is a disease in which the morbid agent is localised in the meninges, and but rarely affects the blood. It was therefore very reasonable to seek to deal with it by the introduction of antiseptic substances into the subarachnoid space, and we have been enabled to satisfy ourselves that this procedure presents the following advantages:—Disappearance of relapses, which are so common in meningitis, a

* Abstract of paper read before the Fifteenth International Congress of Medicine, held at Lisbon, April, 1906.

marked curtailment in the duration of the affection, prompt disappearance of the diplococcus, but moderate loss of flesh on the part of the patient, absence of marked trophic disturbances, and lastly, infrequency of mental troubles, and paralyses and lesions of the organs of special sense which are so frequently affected in meningitis.

In grave cases we have employed subcutaneous injections of ether for the purpose of stimulating the hepatic cells, which are often damaged in meningitis. Cold enemata were also ordered daily and calomel in purgative doses. When albumen was found in the urine, we applied dry cupping over the loins with copious administration of lactose, whereupon the albumen soon disappeared. The patient's diet calls for the closest attention, but should be on a liberal scale.

In tuberculous meningitis the only useful treatment is lumbar puncture, which, at any rate, affords relief. In some cases I have injected antiseptics into the spinal canal but without any beneficial effect.

When we are dealing with a toxic meningitis, lumbar puncture, employed whenever there are signs of compression, gives excellent results. By this means we not only hope to obtain a cure, but to avert hydrocephalus, which is often a late complication of these forms of meningitis.

With regard to the treatment of suppurative cerebro-spinal meningitis of otitic origin, our first care must be directed to the treatment of the auricular lesion.

THE OUT-PATIENTS' ROOM.

ROYAL EAR HOSPITAL.

Deformities of the Nasal Septum.

BY MACLEOD YEARSLEY, F.R.C.S.

AMONGST the out-patients was a male, æt. 33, who for the past two years had been suffering from frequent colds in the head with considerable nasal obstruction. He stated that his tendency to nasal catarrhs had existed for some ten years, but the affection had been worse during the last two. Morning dryness of the throat and a husky voice were prominent symptoms. On examination there was marked granular pharyngitis, the nose showed a septum greatly deviated to the left side, the concavity on the right being occupied by a greatly enlarged middle turbinal body. Mr. Yearsley remarked that more or less deviation of the septum was said to occur in 75 per cent. of all cases of nasal obstruction. It was an interesting fact, he thought, that nasal obstruction was far more common in civilised nations than amongst savage tribes; indeed, according to Morel Mackenzie and Zuckerkandl, a comparative examination of skulls showed that nine out of ten civilised individuals had abnormal noses, whilst those of four out of five savages were normal. A large number of theories, he pointed out, had been advanced to account for this frequent septal deviation, but many of them were erroneous and some of them fantastic. The causes of deviated septum could be reduced to two heads—(1) trauma or injury and (2) faulty growth. Injury might, of course, occur at any age, and, considering the number of falls and blows on the face to which children were exposed, it was not to be wondered at that injury accounted for a large number of cases; probably deviations of the septum would not be so common if more care were taken of nasal injuries in childhood; all such cases, especially when accompanied with much bruising or violent bleeding, should be examined under an anæsthetic and any displacement properly rectified. Deformities of the septum, save those due to injury, were extremely rare in children. It should be remembered, he said, that the septum was not fully developed until at least the age of puberty; indeed, the centre of ossification of the perpendicular plate of the ethmoid did not make its appearance till that time, consequently one had a soft yielding developing structure during the years of childhood which was liable to be injuriously acted upon by any pathological conditions in or about the nasal chambers. In Mr. Yearsley's opinion the most potent cause of faulty growth of the septum lay in repeated nasal catarrhs. Colds in the head were such frequent occurrences that people habitually neglected them, instead of looking upon them as serious disorders requiring treatment. The result was that every cold left its mark upon the nose, and generally more in one nostril than the other. A repetition of such colds sooner or later ended in more or less unilateral nasal obstruction. Since obstruction meant a negative pressure in the obstructed nostril, it did not require much thought to recognise how faulty growth of the septum resulting in deformity could be induced. In children the prevalence of adenoids, so prolific a cause of nasal catarrhs, was probably as, or even more, productive of septal deformity as injury.

Mr. Yearsley pointed out the varieties of septal deformities, a matter, he said, very inadequately treated in the text books. The most common form was that in which there was a double angle formed by an anterior vertical deviation joined below at an acute angle with a second and horizontal deviation, passing from below upwards and backwards and frequently involving the bony septum. The next most common was the single angled deviation formed by the horizontal deflection similar to the one just described, but without the vertical deformity. Then came the S shaped deflection, which might be either horizontal or vertical. Finally there was the C shaped deformity formed by one large bulge. There were also other less common deformities. A fairly frequent condition was that deformity due to dislocation of the septum from the columella. A large number of the so-called spurs or ridges were in reality due to slight deviations thickened at the apex.

The amount of obstruction to nasal breathing caused by septal deformities varied greatly. It must not be forgotten, Mr. Yearsley said, that septal deflections might be complicated by enlargements, complete or partial, of one or other turbinal, by adenoids or by synechiæ. In the present case obstruction was very considerable and was further complicated by enlargement of the middle turbinal on the side of the concavity. How was such a patient to be relieved? Only by surgical interference. The number of operations which had been devised for the rectification of deviated septa was very large. He would mention Asch's operation and Moure's method, which were well known; they were both only adaptable to certain forms of deformity. Many rhinologists were content to rectify a deviated septum by forcible smashing with appropriate forceps, with or without the aid of a nasal saw, followed by the wearing of splints. Recently a more scientific method had been introduced known as the submucous resection operation. This was what Mr. Yearsley proposed to do for the present case. It consisted in the raising of a large muco-periosteal flap and the complete removal of the whole cartilaginous and bony septum. The result was a straight septum, consisting of fibrous tissue covered by the nasal mucosa. In the present case this would have to be preceded by the removal of the enlarged middle turbinal.

OPERATING THEATRES.

ST. PETER'S HOSPITAL.

EXTERNAL URETHROTOMY. — MR. SWINFORD EDWARDS operated on a man, about 35, who had been admitted to the hospital with difficulty of micturition. He had been attending the out-patient department

for two weeks, during which time several attempts had been made to pass an instrument but without success; indeed, every attempt was attended with considerable hæmorrhage. It was hoped that under an anæsthetic a pilot bougie might be passed, thereby enabling internal urethrotomy to be performed. The patient having been anæsthetised, several varieties of pilot bougies, both straight and corkscrew, failed to reach the bladder. An attempt was then made to pass a Maisonneuve's urethrotome without the pilot, but this and likewise several steel bougies also failed even when aided with a finger in the rectum. The operator then had recourse to various whip bougies, but as these failed and considerable hæmorrhage was occasioned it seemed apparent that the tract of the urethra had been left and some false passage entered. Perineal section was therefore decided upon, and the patient placed in the lithotomy position. A Wheelhouse's staff having been passed down as far as it would easily go—namely to the region of the triangular ligament—an incision was made on to this in the usual manner. The end of the staff being exposed it was thrust through the wound, the upper extremity of which was thus held up. The external walls of the incision were now pulled apart by pressure forceps, but no urethra was seen at the bottom of the wound; it was therefore clear that the staff had passed into the false passage which had thus been laid open. After some few minutes spent in search of the urethra, it was found lying to the left of the false passage; the urethra was opened and a bougie passed onwards into the bladder without any difficulty. The staff was now withdrawn and one or two attempts made to pass it from the meatus into the urethra, which had been laid open, but unsuccessfully; so a fine gum elastic bougie was passed in the opposite direction, that is to say, from the wound, out through the meatus; this was accomplished without difficulty. The end of the bougie was now securely fastened to the extremity of a No. 12 Condé catheter by means of silk; in this way the catheter was brought through into the wound, the guide bougie next detached, and the catheter passed on through the proximal portion of the urethra into the bladder aided by the finger in the wound; the incision in the urethra was closed by a fine catgut suture as far as possible. Another layer of buried sutures brought the deeper parts together, especially in the anterior portion of the wound. A few silk-worm gut sutures were also used to approximate the edges of the wound, except at its posterior or under part, into which a drain was passed with some gauze packing. The operation was completed by fixing in the catheter in the usual way. Mr. Edwards remarked on the difficulties attending this case. He said that it was unusual to meet with a false passage opening into the urethra as far forward as had been met with in this case; indeed, he estimated that this lesion was situated within three inches of the meatus and it was clear that the hæmorrhage, which had attended all attempts at catheterism, had been due to the instruments passing into this false passage, which had tunnelled the corpus spongiosum urethræ. During the operation, no real stricture had been encountered, though it was possible that the patient might have suffered with some form of congestive stricture in the penile urethra. The operator further remarked that this must be considered as quite an unusual case and must have been occasioned by injudicious attempts in the way of too much force having been used at catheterism before the patient presented himself at the hospital. Ninety-five per cent. of the cases of stricture in which operation was necessary were, he said, submitted to internal urethrotomy at this hospital, for where a guide could be passed through into the bladder it could almost certainly be followed by the urethrotome. The chief thing was to have a good supply of guide bougies, both straight and of the corkscrew pattern; a properly made pilot bougie, which might be of various sizes from No. 1 to No. 4 French gauge should not be too flimsy or string-like, but should have a certain amount of backbone approaching to some extent the character and consistence of the whalebone bougie, but these, he admitted, were not always easy to be obtained. The reason that he preferred internal to external urethrotomy in cases of stricture was because in the first place there was less risk to life and in the second place the convalescence was much more speedy, being in the proportion of one week for the internal as against four for the external operation, the records of the mortality after the internal operation as practised at St. Peter's being not more than 2 per cent.

It was satisfactory to note that the patient was doing well, and was on the high road to recovery.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Aug. 12th, 1906.

Created Abscesses.

The creation of abscesses had been recommended for the first time by Fochier, in 1895. The beneficial *rôle* of local lesions, says Prof. Lemoine, in general infectious diseases seemed to him to justify the method. He first tried it in puerperal fever by injecting from 15 to 30 drops of essence of turpentine beneath the skin. He provoked thus an abscess which seemed to arrest the disease. The experiments of Fochier were followed by those of Dieulafoy, Bard, Lépine, in 1897. These authors applied the method with success to pneumonia and broncho-pneumonia, typhoid fever, cerebro-spinal meningitis and erysipelas. Chanteuress and Rendu, on the other hand, seemed to derive no benefit from it, but the reason was that they employed the method *too late* after all other means were exhausted, and as a sort of *pis aller*.

The success of Carles, Prieur, Courtin, in broncho-pneumonia, and that of Probst in cerebro-spinal meningitis proved beyond doubt the utility of the creation of local abscesses in the above affections.

Prof. Lemoine, for his part, had applied the method in several cases of suffocating catarrh, with surprising success. The injections never exceeded a cubic centimetre at the time, but it was repeated the following day in two or three cases. The region chosen was the external portion of the thigh or the side of the thorax. The injection is very painful, as it provokes a circumscribed phlegmon, but may be relieved by warm, moist compresses. The pus is formed in five or six days, and the abscess may be opened towards the eighth day, but it heals very slowly.

The mode of action of these abscesses is difficult to elucidate, but Dieulafoy and Laverau believe that under their influence a regular mobilisation of leucocytes which crowd the lungs occurs, directing them into the general circulation.

The creation of an abscess, says Prof. Lemoine, is an heroic method which should be employed in grave general affections, which ordinarily terminate fatally.

Puerperal fever, suffocating catarrh, and cerebro-spinal meningitis, are the cases which justify the method on the condition that it is employed at an early date, and is never attended with dangerous consequences when ordinary antiseptic precautions are taken.

Pneumonia and Camphor.

The treatment of pneumonia by camphor, given by

the mouth or injected subcutaneously, is strongly recommended by Dr. Scheffler. The hypodermic injections should be reserved for cases where the heart is failing, and the solution employed is that of camphorated oil (1 in 10). One or two injections daily. The camphor, however, would seem to have a more effective action when administered by the mouth:—

Camphor, 15 grs.;
Tincture of chinchonæ, 1 drachm;
Glycerine, 1 drachm;
Syrup of tolu, 4 ounces;
Syrup of orange, 1 ounce;
Water, 5 ounces.

A tablespoonful every hour. The camphor acts as a tonic of the nervous system.

TUBERCULOUS GANGLIONS OF THE NECK.

General treatment: Live in the open air as much as possible, sleep with window open at night, substantial diet, cod liver oil, arsenic, cacodylate of soda.

Local treatment:—

Iodide of baryum, 4 grs.;
Iodide of potassium, ½ drachm;
Axonge, 6 drachms.

Injections into the ganglion of—

Fowler's solution, 1 drachm;
Distilled water, 1 drachm.

Inject two drops into the ganglion and wait two or three days to allow the local reaction to subside. At the end of a week, inject four drops.

The treatment is tedious, and only succeeds when the ganglion has a tendency to soften.

The best treatment of all is radiotherapy, but it should be done by a specialist, unless one possesses a complete installation for the production of the X-rays. The main idea in the treatment by this method is to cause to be absorbed as many rays as possible in maintaining the integrity of the skin, and this can be effected by allowing sufficient intervals between the séances. Eight days should be allowed between the two first séances, twelve days between the second and third, and fifteen days between the others. The first effect of the treatment is a kind of softening of the pourtour of the ganglion. The ganglions separate and diminish in volume by the formation of cicatricial fibrous tissue.

How long should the treatment last? Seven or eight weeks. If at the end of that time no effect has been observed, it might be continued for another similar period; and if there was still no result, it should be abandoned and the arsenical injections renewed.

Besides the local action, radiography produces an improvement in the general condition; sleep becomes better, the weight increases, the appetite improves strength returns and the blood becomes modified. Radiography requires a great deal of prudence on the part of the operator on account of possible accidents: erythema, pigmentation of the skin, falling of hair or beard, headaches.

GERMANY.

Berlin, Aug. 12th, 1906.

[FROM OUR OWN CORRESPONDENT.]

AT the Society fur Innere Medizin, Dr. v. Leyden showed

(1) PREPARATION OF KIDNEY DISEASE AFTER LEAD INTOXICATION.

Slight albuminuria, he said, often came on even after only short handling of lead; cases of chronic nephritis passing on to contracted kidney were more rare. The patients passed copious quantities of urine with symptoms of stasis and dropsy. The urine resembled that of contracted kidney in having a low specific gravity, containing but little albumin and sediment The sufferers gradually became worse, dyspnœic, and died, with symptoms of uræmia and collapse. The man from whom the preparations were taken was æt. 40; he had suffered from lead colic even as early as his twenty-second year. Six months ago asthmatic troubles began, through which he had to give up work; the specific changes in the blood corpuscles could not be determined. The patient was very much reduced on admission into hospital, pale and dyspnœic. Some days later he died somnolent and suffering from dyspnœa. The autopsy showed the heart to be greatly hypertrophied, but not dilated, as was usually the case; on one wall was a marianthic thrombus on the trabeculæ, plainly a result of diminished activity of the heart. Such pure hypertrophy was observed but rarely. The kidney showed red granular atrophy, a number of glomeruli were contracted, others were degenerated. Amongst the latter the capsule was thickened, the vascular loops were degenerated and red, there was no epithelium or cells in them. There were also glomeruli that were intact. The intervening tissue was increased and extended by pure connective tissue fibres. The canaliculi were partly contracted but little altered in structure. The vessels showed thickening and narrowing of their lumens. The thickening affected the adventitia, the narrowing of the lumen was due to thickening of the intima; there were no signs of inflammation. There was therefore no proper nephritis in the case, but a disease of the renal blood vessels, with subsequent contraction of the kidneys. The disease differed, therefore, from the usual form of contracted kidney. The disease and its symptoms were similar to that described by Traube in his day.

From all this, the setting up of forms of kidney disease from their ætiology that could scarcely be distinguished by their symptoms was justified. A distinct contraction of the kidney was not always met with, but only one of the renal and vascular systems.

(2) GENERAL METASTASIS OF CANCER AFTER OPERATION FOR MAMMARY DISEASE.

The case was that of a woman, æt. 40, delicate and pale, whose breast had been removed for cancer two years before. There was a smooth round cicatrix, and the regionary glands were not swollen. The patient complained on admission of trouble in the chest, and the X-rays showed shadows in two places that might represent tumours. She remained a long time without any special trouble, even improved a little, and then an affection of one eye began, with pain and diminished power of vision. On examination, a small white, probably carcinomatous, tumour was found on the retina. Similar symptoms then appeared in the other eye, and here also Greef found a tumour on the retina. One day the patient became worse, complained of violent headache, and died quickly. The autopsy showed a surprisingly and rarely met with condition. At the spot where the mamma was amputated there was a smooth cicatrix, no recurrence, metastatic nodules the size of walnuts were present in the lungs, as shown by the X-ray shadows. Nothing abnormal in either heart or liver. In the brain there were a large number of small metastases, well over twenty, which were associated with the retinal tumours. The kidneys, of normal size, showed a large number of white enclosures, metastases also in the supra-renal capsules, in the spleen; no metastases in the uterus or muscles. It was rare that after operation for carcinoma so many metastases were found in nearly all the organs. He had seen similar cases, however, lately, where the disease had been removed early and completely. He had seen one case in private practice and two in hospital. One of the latter was a case of stenosis of the œsophagus in a woman. She had had the left mamma removed about six months before for carcinoma; she now showed dulness on the left side of the chest; after puncture improvement in the stenosis took place, so that she was discharged from the hospital at her own request. In a second case the metastases appeared four months after the operation. One got the impression in such cases that there was some infection. Fifty years ago there was an opinion abroad that carcinoma should not be operated on, as metastases appeared the more quickly, and even when early operation had been performed

In any case, cases such as those just described were remarkable, and gave food for thought.

Hr. Beitzke, who had made the autopsy, said there were no enlarged axillary glands. The way of the metastases was through the supraclavicular glands and from there into the lungs. The vena anonyma had been penetrated on both sides. The recurrent laryngeal nerve was embedded in the metastatic growth, and this caused some hoarseness. There were metastases in the vertebral column, in the femurs, in the bony skull, the thoracic duct, and in the pancreatic duct. The metastases in the brain and eye were of a hæmatogenous nature, and were not directly connected. The ovaries were readily attacked in cases of carcinoma of the stomach, but only rarely so in mammary cancer.

AUSTRIA.

Vienna, Aug. 12th, 1906.

Cardiac Stab Wound Healed.

Hesse recorded a case of wounding of the heart which he treated with perfect success. The lad, who was 13 years of age, received a wound from his comrade on the 8th of June, 1905. The diagnosis was a penetrating wound of the thorax with hæmorrhage. Whether the wound had penetrated the heart or only the mammary and intercostal arteries could not be determined till an opening was made. He was run into hospital fifteen minutes after the accident, and operated on within an hour after admission.

An opening was made in the fourth intercostal space on a level with the stab, from which the blood flowed profusely. After widening the opening, the pericardium was pushed back, which caused an inrush of air to the pleural space. At this stage the direction of the penetrating wound was explored and found to have entered at the cartilaginous end of the fourth rib and passed obliquely towards the heart, running through the pericardium and entering the heart itself. The third rib was sawn, a convex incision made in the pericardium, and the cardiac muscle exposed. There was not a great deal of blood in the pericardium, although a good wide wound was observed in the heart. The stitching of the cardiac wound was a troublesome operation owing to the narrow space and no means of fixing the heart. To obtain perfect drainage a pair of sharp-pointed forceps was passed round the pleural space and another opening made in the thoracic walls below the scapula.

During the first two weeks the course was not without a great deal of anxiety. The first difficulty was a sero-purulent pleuritis with pericarditis, high temperature and a small rapid pulse subsiding about the fifth week. On the 30th of March, or nine months after the operation, the patient was dismissed with an opening in the left side and slight scoliosis in the spine. The heart was now lying to the middle of the sternum, and opposite the space where the portion of rib had been removed. At the base of the heart a dry rubbing synchronising with every pulsation is to be distinctly heard, while the pulse has fallen to 80.

Since his return home no bad effects have presented themselves, but is still unable to do any kind of work. The left lung has greatly improved in function, while the scoliosis has almost disappeared; but there still remains an opening of about two square centimetres, and the pulse 72.

Infantile Mortality.

Dehne next read his report for Leopoldstadt on the death of infants under one year in his department. After stating the condition under which the society took charge of the indigent poor by a note from the poor law officer, he stated that his duty was solely prophylactic, and one which consisted in the admonition of the mother to suckle her own child in spite of all temptation, and for which the society offered a premium. The first instruction for those who could not feed their own child was to use goat's milk.

Where artificial foods were preferred or rendered absolutely necessary, he advised the artificial food to be used with a little weak sterilised cow's milk. After a few remarks on the technique of the prescription. he gave the total number supervised as 869 for 1905 under one year; at the end of the year 370 were under observation. The average attendance was 3·11 months, and the total number of attendances 81,080, or an average number of children to be attended per month 280. Most of the children averaged 4 weeks to 3 months during attendance. The annual consumption of milk was 68,068 litres. Besides this, Szekely and butter milk as well as Liebig soup was ordered. Of the 869 children 439 were fed at breast, with additional milk as age advanced; but 252 were purely breast fed. There were 187 fed on goat's milk entirely, and 243 fed on the artificial food. Putting the partially fed on breast and artificial food together, which is 430, 80 of them died within the year, making 186 per thousand; purely breast fed 17, or 67 per thousand; fed on goat's milk 14 or 75 per thousand, making 111 deaths in the 869 children.

Of these deaths, 27 or 24·3 per cent. died of gastro-intestinal disease, one of them being breast fed, and two from those fed on goat's milk; while 28 or 25 per cent. died from diseases of the air passages. The greatest death rate was in July, 4·5 per cent., August 4·3 per cent. (diarrhœa), November 4·3 per cent., and April, 3·7 per cent. from pneumonia, &c.

BRITISH HEALTH RESORTS.

[FROM OUR OWN CORRESPONDENTS.]

MATLOCK BATH.

Few who have not visited the Peak district of Derbyshire can quite appreciate that there are two Matlocks. Matlock Bath to the uninitiated is Matlock with its baths. Even the express trains of the Midland Railway do something towards the perpetuation of this idea, by running through the little station of the one and stopping at the larger terminus of the other. Yet there is a space of more than a mile between the two towns; Matlock being a large place boasting of several hydros, whereas Matlock Bath can show but one street, no hydros and but one hotel of considerable dimensions. In this connection the question naturally arises, why do medical men send their patients to the latter? The reply to this is, simply for its baths and mineral springs. Matlock has no mineral spring, and the hydros are dependent upon the ordinary town water supply for baths and douches, whereas Matlock Bath has a valuable mineral spring, the water of which is tepid, and almost identical in properties and composition with that of Aix-les-Bains. The little town differs in no way from hundreds of other small communities. It is governed by a district council composed chiefly of small shopkeepers, who are unable or unwilling to take a broad view of their surroundings, or to see that their interests lie beyond the attraction of the tripper, in whose behalf almost every second house has in its windows the familiar announcement of "dinners and teas," and the occupation of its inhabitants would appear to be chiefly diverted to this one channel. To a visitor, especially to one connected with the medical profession, this would appear to be an inexplicable anomaly. Nature has here concentrated her beauties with a lavish hand. Switzerland in miniature, without its snowy peaks it is true, but without the trouble or danger of climbing them. Whether one views the scene from the High Tor above, or midway from the Royal Hotel, or from the Derwent Valley below, it is one of singular beauty, and should attract the well-to-do in great numbers when better known, instead of being handed over as it appears to be wholly to "the tripper." A well known authority once hazarded the opinion that "when Nature had completed Switzerland, there was left one beautiful fragment for which she had no

further use in that country; so she set it in Derbyshire amid a framework of romantic hills, called the Gem of the Peak." This spot is Matlock Bath for which a great future would appear to be assured, notwithstanding the apathy of its district council. Until a few years ago, there was nothing to attract visitors beyond its antiquated baths, and for lack of enterprise the place was regarded as a relic of the past. Much has recently been done to revive its lost popularity, not, be it recorded, by the town authorities, but by the proprietors of the principal hotel through whose grounds the mineral springs run. About two years ago the baths were entirely remodelled, under the direction of Dr. Cecil Sharpe, who has visited most of the Continental Spas, and was enabled to turn to practical purposes the experience thus gained. These baths are placed in the basement of the Royal Hotel, so that patients can descend from their rooms and up again by the lift without the risk of a chill which the separation of spas from hotels elsewhere necessitates. Herein can be had every conceivable form of hydropathic treatment, from the natural mineral water bath of the district, to those of Aix, Vichy and Nauheim of the Continent. But the special feature which is at present attracting the attention of the medical profession, is the treatment of rheumatism, gout, neuritis and kidney disorders by Fango di Battaglia. This substance is imported from Italy, and treatment by it can at present be obtained only at Matlock Bath in this country. It is composed of the volcanic mud thrown up by the hot springs near Padua, and is the origin of the mud baths about which so much has been written. The writer can speak of its effects from practical experience. He visited Matlock Bath with his knee stiff and painful from rheumatism. After half a dozen applications of Fango, the pain and stiffness were gone, and he was able to indulge in lengthy walks with comfort. It may be mentioned also, *en passant*, that the Royal Hotel where the baths are situated is excellently managed and home-like, the sanitary arrangements aothtc, nissud anpie avob patients sent here to undergo "the cure" appear to receive great benefit therefrom. It is, moreover, open all the year round, and as, from the depths of its valleys and the great height of its hills, almost any climatic temperature may be reached, it is well that such a health resort near home should be known.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

PROFESSORSHIP OF PHYSIOLOGY AT GLASGOW UNIVERSITY.—The King has been pleased, on the recommendation of the Secretary for Scotland, to appoint Diarmid Noël Paton, M.D., to be Regius Professor of Physiology in room of Professor J. G. McKendrick. Dr. Noel Paton was born in 1859, and is a son of the late Sir J. Noël Paton, the well-known artist. He was educated at Edinburgh, Vienna, and Paris, was a Baxter scholar in natural science, and held a biological Fellowship at Edinburgh University. Dr. Paton has for many years been engaged in teaching physiology in the Extra-Mural School in Edinburgh, while his position as superintendent of the laboratory of the Royal College of Physicians has proved his capacity both for carrying out original research and inciting others to do the same. He is well known as a distinguished physiologist, especially through his studies in dietetics, on the functions of the ductless glands; while he has also published a number of valuable researches in connection with the life-history of the salmon. Dr. Paton has ever been a most popular teacher in Edinburgh, and his influence for good and public spiritedness have always made themselves felt in all matters connected with medical education. His training, though in the main physiological, has brought him so much in contact with cliniciens that he has always in teaching emphasised the practical rather than the purely scientific aspect of physiology; he has never forgotten, as some physiologists are apt to do, that their pupils are going to be doctors, not physiologists. Dr. Paton will be greatly missed on his departure from Edinburgh, but all his friends there feel that in him Glasgow has got the right man for the post.

LETTERS TO THE EDITOR.

THE SUPPRESSION OF QUACKERY

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The conviction of the quack, Richard, referred to in your leader of August 8th is, so far, satisfactory, but it must be borne in mind that he was not charged with offences against medical law, not with falsely pretending to be a legally qualified practitioner, and that it will be impossible systematically to cut short the careers of the hundreds of similar rogues until necessary new legislation is provided, together with a public prosecutor not only empowered but obliged to enforce it. The case of the convict Bridgwater, sentenced to penal servitude about a year ago, illustrates the same fact. Under cover of a sham "medical institute" he had been engaged in practice for years, fraudulently pretending to be a "doctor," and carrying on his nefarious schemes unchecked. Thousands of victims had passed through his hands; no attempt to interfere with him had been made, and he might have gone on indefinitely had he not become engaged in the extensive scheme of forgery and fraud which brought him at last within the clutches of the police. I venture to repeat now the assertion which I have made over and over again in your columns, as well as in other medical papers, namely, that it is hopeless to expect any effective and sufficient amendment of medical law to cope with quackery until the public and the legislature shall have become completely enlightened upon the subject. Not only the general public but the great majority of members of both Houses, including all those lawyers who have had no professional experience of the working of medical Acts, are almost entirely ignorant of the evils and abuses at present prevailing. They are quite unable to realise that reform is called for much more for the protection of the public than for the advantage of the profession.

The hideous story of quackery in which is always included the quack medicine trade, needs fully exposing in public. If the story were once and at full length publicly told it would put to shame newspaper proprietors who are now the chief abettors of quackery, and might induce some, if not all, of them to endeavour to make amends by working for the medical law reform so urgently called for. The entire Press, including *The Times*, has so to say bound itself over in opposition to medical reform. The erstwhile leading journal, as you have shown, now derives a large part of its income from quack advertisements of the classes formerly denounced in its editorial columns, and with this example before them it is not to be expected that lower class papers will refuse to augment their incomes by similar means. At present no paper dares to attack quackery, or to give prominence to or comment upon the exposures which are so frequently made in the higher courts of law as well as before coroners and magistrates. The only way by which the whole shameful story can be laid bare lies through the medium of a Royal Commission This I have over and over again urged. I would venture once more to press it upon the attention of the profession. A Royal Commission would have power to call witnesses to examine them on oath and to keep them afterwards free from the danger of prosecution for libel on account of their statements In spite of the political weakness of the profession they could surely obtain the appointment of such a commission if the case were presented and supported by medical M.P.'s and their sympathisers within the House. Commissions on much less important ques-

tions have been appointed within recent years. The case against quackery in every form could be easily proved. Chemical analysis would show the worthlessness of pills, nostrums and panaceas; and the injurious and deadly effects of relying upon them in serious diseases could be demonstrated. The records of the courts supported by a host of skilled witnesses could prove the harmfulness of practice by unqualified pretenders, and it is impossible that the revelations should not touch the consciences of the thoughtful public and of leading statesmen. In obtaining, organising and presenting the evidence, expense would be involved, and this the profession, comparatively poor as it is, could surely afford. There must be many more besides myself who would be willing to contribute to a fund. If a scheme can be started for promoting legislation against medical quackery in every form, the first step to be an agitation for a Royal Commission such as I suggest, I shall be glad to contribute £50 towards a preliminary guarantee fund of £5,000, provided ninety-nine others will put down a like amount or the money be subscribed in lesser sums. The medical profession have always been and are now the chief promoters of all measures for the improvement of the public health and for the protection of the welfare of the people. No greater service could be performed at the present juncture than an attack properly organised upon the gigantic and still growing system of quackery and fraud, the character of which has through past years and lately been so fully exposed in The Medical Press and Circular.—I am, Sir, yours truly,

Henry Sewill.

Cavendish-square, August 9th, 1906.

SENSATIONAL JOURNALISM.

To the Editor of The Medical Press and Circular

Sir,—I enclose a newspaper cutting for your perusal. Is this London hospital recognised by the profession? As a den for charlatans it could not be surpassed for its *charivari*.

What would the Medical Council think of my conduct should I dare to hint at such a practice; yet "respectable professors" descend to the lowest tricks of a mountebank? It is not my object to discuss the blemishes and defects of the Finsen rays, as the results are very enigmatical and questionable if they justify the means. The question occurring to my mind is the morality of such an institution.

"It has more than once happened that people meeting at a hospital ward for treatment have formed attachments and have been married. In some cases these unions are deplorable. For example, two epileptics who attended the out-patients' department of a London hospital got married. After marriage they still attended, and now they bring with them three young children also victims of the disease."

Could anything be more harrowing than this painful revelation that charitable institutions should be the means of bringing such offspring into the world to be maintained by the poor rate? It is surely high time these institutions were closed entirely or put under better control. The London hospital is first advertised as a fine matrimonial centre that the public are very pleased to charitably maintain; that Professor Mountebank performs daily, and that all imbecile offspring are voluntarily supported by the parish and liberally educated at the institution for 'defective children!" Could anything be more absurd or repulsive to a sober mind? Can you tell, Sir, on what grounds this horror can be justified, or how long it must be perpetrated with impunity?—I am, Sir, yours truly,

Nolle Prosequi.

Bootle, August 9th, 1906.

[The cutting of our correspondent is too long to reproduce. It is an extract from *The Daily Mail* of August 9th, and is written in the usual sensational style of that journal. It describes various romances between patients at the London Hospital who suffered from lupus and other unattractive diseases. It is a pity that such stuff should ever "find its way into the papers."—Ed.].

SNOBBERY IN THE ARMY NURSING SERVICE.

To the Editor of The Medical Press and Circular.

Sir,—My attention has been drawn to the comments in your last issue on the above subject. Allow me to verify the remarks which you quote from the *Army and Navy Gazette*. The nurse hunted out was a Miss C., and the lady who carried her case before the Courts a Miss R. The Army Nursing Service under the new Army Nursing Board is purely "class despotism," and that is the why and wherefore of its ranks being under establishment. You urge an inquiry. Catch the authorities giving one, and thus disclosing their own misdoings. The Army nurses are in excess of requirements, and from all quarters a demand for a full and independent inquiry is heard. Snobbery is rife.

I am, Sir, yours truly,

One in the Know.

August 4th, 1906.

OBITUARY.

OSCAR THOMAS WOODS, M.D.

We regret to record the death of this highly-esteemed member of our profession, which took place on August 2nd, at the comparatively early age of fifty-eight. Dr. Woods was son of the late William Woods, Esq., of Parsonstown, and nephew of Dr. Thomas Woods, who died not long ago, full of years and honours, after considerably more than half a century of devoted service to humanity and science in his medical practice at Birr. Dr. Oscar Woods was educated at Trinity College, Dublin, and graduated in arts in 1868, and in medicine in 1869 at the University of Dublin. He adopted the specialty of psychiatry early in his career. He served as Assistant Medical Officer in one or two asylums in England, and it is an extraordinary proof of his amiability that after this long lapse of time he is still remembered with affection by a few surviving patients and colleagues in the institutions where he worked in that country.

In 1875, he was appointed from the Senior Assistancy of the Warwick County Asylum to the post of Resident Medical Superintendent of the Killarney District Asylum, and in 1890 he was promoted to the important charge of the District Asylum, Cork, an office which he occupied till the time of his death. In 1901 his colleagues in his specialty conferred upon him the highest honour in their power by electing him President of the Medico-Psychological Association of Great Britain and Ireland. The annual meeting held that year at Cork under his genial presidency was one of the most successful and agreeable assemblies which that great Society has ever called together.

Dr. Oscar Woods was a most conscientious, high-minded, and hard-working superintendent, interested in every branch of his complex and onerous work, uncomplaining and self-sacrificing in his devotion to his duty. The remarkable progress made at the Killarney Asylum during his rule, and the great reforms effected at Cork after his appointment, attest his high qualities. Lack of time and incessant worry hindered him from writing as much as he otherwise would, but his occasional contributions to medical literature, published in the *Journal of Mental Science* and elsewhere, showed what he could have done under more favourable circumstances. His excellent qualities met the usual appreciation accorded to members of the medical services in his country of late years. He had not the suppleness nor the "policy" required for dealing with public bodies intoxicated with the consciousness of new-found powers. Most undeserved vilification, perpetual "pin-pricking," and incessant annoyance were his lot. The echoes of disputes about his administration were not even stilled around his death bed. The depreciation of health

from which he suffered before the oncome of his fatal and painful illness (cancer of the liver) was probably due in great part to constant worry. He suffered also under poignant family trouble. His second son, a lad of much promise, died after a brief illness, and his eldest and favourite daughter soon followed. These repeated blows told heavily upon him. He was a man to whom the buffet of fortune seemed specially unjust, for he was of an affectionate disposition, perfectly straightforward, full of blunt good-nature, and incapable of unkindness or double dealing.

Dr. Woods leaves a widow and six children to mourn his loss. He will be regretted by everyone in his own specialty, and by all the members of his profession who had the advantage of knowing him.

DR. G. B. FRASER, WESTON-SUPER-MARE.

WE regret to announce the death of Dr. G. B. Fraser, of Weston-super-Mare, on August 8th. On the day that he was taken ill (July 9th) Dr. Fraser gave evidence at an inquest, and later performed an operation. An hour or so afterwards he was seized with severe illness, and took to his bed. Dr. Fraser had practised in Weston-super-Mare for many years. He was fifty-four years of age. Of a most genial disposition, the doctor was generally beloved, and his goodness of heart was manifested by the devoted services he rendered to the Royal West of England Sanatorium and Children's Convalescent Home as honorary medical officer. For some years he held rank in the Devon and Somerset Volunteer Engineers, and only a fortnight ago he was granted the honorary rank of Surgeon-Colonel, on resigning his commission, with permission to retain his rank and wear the prescribed uniform. Dr. Fraser was the second son of Mr. Peter Gordon Fraser, some time Colonial Secretary of Tasmania, where he was born. He was educated in England, and after a successful medical training he obtained his professional degrees, and was appointed house surgeon at St. Mary's Hospital, London. Subsequently he succeeded to the practice in Weston-super-Mare of the late Dr. Julius Wilmott. During his long residence in Weston-super-Mare he won the respect of all classes, his sympathetic nature endearing him to all, especially the children.

DEPUTY SURGEON-GENERAL H. F. SMITH, M.D. ABER., M.R.C.S.

DEPUTY SURGEON-GENERAL H. F. SMITH, late of the Army Medical Department, died on Sunday, the 5th inst., at Graitney Hall, at the age of 82. Qualifying as a member of the Royal College of Surgeons, England, in 1846, he joined the Army as an assistant surgeon in March, 1847, and having taken the M.D. degree at Aberdeen in 1850, served throughout the Eastern campaign of 1854-55. He had medical charge of the staff belonging to the Adjutant and Quartermaster-General's Departments, and was subsequently on the personal staff of Sir James Simpson and Sir William Codrington. He was present at the action of Bulganac, at the battles of the Alma, Balaclava, and Inkerman, and throughout the siege of Sebastopol till the fall of the fortress, receiving for his services the medal with four clasps, the Turkish medal, and the Fifth Class of the Medjidie. In 1859 Dr. Smith was admitted a member of the Royal College of Physicians, London, and in March, 1867, was promoted surgeon-major. He retired in 1875 with the rank of deputy surgeon-general.

JOHN HUDSON, M.D.LOND.

DR. JOHN HUDSON died on Monday, the 6th inst., at his residence in Cork Street, Burlington Gardens, in his eighty-eighth year. Dr. Hudson, who had long retired from practice, was professionally educated at Leeds and in London, and qualified as a member of the Royal College of Surgeons, England, and a licentiate of the Society of Apothecaries in 1841, taking the M.B. degree at London University in 1842, and the M.D. in 1846. Dr. Hudson was for a considerable period resident medical officer to the "Dreadnought" hospital ship.

DR. F. B. O'FLAHERTY.

THE death of Dr. F. B. O'Flaherty, of Liverpool, took place on Wednesday, at the residence of his uncle, Dr. Brannigan, 109, Upper Parliament Street, at the age of 45. Dr. O'Flaherty, who practised in Park Road and neighbourhood, was one of several brothers. The interment took place in Flaybrick Hill Cemetry, Birkenhead, on August 3rd, at noon.

LITERARY NOTES.

THOSE interested in voice-production will find yet another system propounded in "A New Method of Respiratory Vocal Re-Education," written by F. Matthias Alexander, and published by Messrs. Bailliére, Tindall and Cox. It is perhaps hardly fair to criticise the pamphlet, as the author aims only at giving his readers an introduction to his methods, and promises fuller details later. At any rate, Mr. Alexander points out some common errors in voice production, and if his system can teach people so to re-educate their respiratory mechanism as not to fall into them, he will have something substantial in his favour.

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"The Levantine Riviera, Italy," by W. T. Beeby M.D., will give its readers a glimpse into a region which is at present undreamt of in their philosophy. And a charming region it is, too, we judge from the description. Not that Dr. Beeby puts the butter on "thick," for he writes with commendable restraint, but because the historical associations and natural beauties of the Levantine Riviera combine to make it an unusually attractive winter resort.

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Two simple little pamphlets dealing with early training in a popular fashion are "How to Live," by Richard Caton, M.D., F.R.C.P., J.P., and "Baby," by Edith L. Maynard.

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THE former aims at being a primer for pupils in elementary schools, discovering to them the principles of healthy living; whilst "Baby" tells the poorer classes of mothers how to treat their infants. Although we might have written them differently ourselves we can say that they both fulfil their humble but necessary functions fairly well.

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"Public Health Acts and Other Sanitary Laws and Regulations," by Martin Elliott, Barrister-at-Law, and Gilbert Elliott, M.R.C.S., L.R.C.P., D.P.H. (H. K. Lewis), seeks to give a concise *résumé* of the sanitary laws as they stand at present. Being little else than an abstract, it does not call for much in the way of comment, though it may be found of value by students working for the Diploma in Public Health. It is curious that the authors should speak of "my brother Gilbert Elliott" in a preface signed by them both, and even more so that the Public Health (London) Act should be passed over in silence.

THE Duke of Northumberland is taking an active interest in the arrangements connected with the second International Congress of the Association for the Promotion of Hygiene and Salubrity in Dwellings, to be held at Geneva from September 4th to 10th. Representatives from all the countries of Europe, the United States, and Canada will attend. Dr. Vincent, State Councillor of the Canton of Geneva, will be the president of the Congress.

THE P. and O.'s mail steamer "Arabia," on her arrival at Plymouth on Saturday, reported a case of plague on board. The patient, a Lascar seaman, has been isolated, and the passengers and crew medically examined.

SPECIAL ARTICLES.

JAPANESE MEDICAL HEROES.

It is certain that Japan will in no distant future take a foremost place in the ranks of scientific medical progress. So far as military surgery is concerned, Japan has already secured a position second to none. The records of Japanese army work during the recent war stand *facile princeps* in the annals of history.

Dr. Umeno.

Dr. Shigo

Dr Sakarnote.

Under these circumstances it is interesting to know anything personally about the men who are making this particular kind of history in Japan. We have much pleasure in reproducing from a recent copy of the *Tokio Graphic* the portraits of three distinguished natives of Japan. They are Dr. Shigo, decorated by the Emperor for his discovery of the dysentery bacillus. Dr. Umeno, who obtained a similar honour in recognition of his research work in vaccines, and Dr. Sakarnote, whose distinction was granted because of his invention of the electric vitascope.

LABORATORY NOTES.

STERILISED VAGINAL SUPPOSITORIES.

We have received from Messrs. Parke, Davis & Co. two vaginal suppositories that should be of much value to the general practitioner who is called upon to attend midwifery cases. They are of two kinds, as suggested by Dr. W. P. Manton: No. 1—Contains five grains of iodoform each; No. 2—Contains five grains of boric acid and three grains of aristol each. They are intended for post-partum use, both as checks to microbic development, and for healing lacerations of the cervix or perinæum. By this means a sustained local effect is obtained, which is likely to be more productive of good results than simple vaginal douches. In the preparation of these suppositories the utmost care is taken to ensure asepsis. The ingredients, wrappers and the operatives' hands are, we are informed, scrupulously sterilised before the work is commenced. These suppositories are packed in sterilised tubes and furnish medical men with a handy and trustworthy means of securing asepsis after delivery.

ETHOL SOAP.

Messrs. Parke, Davis & Co. have sent us samples of a new fluid soap which possesses a remarkable affinity for grease. It is free from strong alkalies or anything that could injure the skin, yet exerts a strong solvent action on oil and fat, and is consequently a great boon to motorists, cyclists and amateur machinists, who are liable to get their hands soiled with greasy dirt. A little is poured into the palm and worked over the hands, water is then added and a lather raised in the usual way. On rinsing with water it will be found that the grease has been effectually removed.

Ethol is supplied in metal screw-cap flasks of two sizes, the smaller being particularly suitable for carrying in the pocket.

The same firm have also prepared a granular effervescent laxative lithia. The preparation is composed of pure ingredients, and when dissolved liberates a large amount of carbonic anhydride which provides a sparkling and agreeable draught. Each teaspoonful contains 5 grains of lithium citrate and 30 grains each of potassium citrate and sodium phosphate. The laxative principles are present in quantity sufficient for ordinary requirements. These granules are supplied in bottles of 2 ounces and 4 ounces, and we can testify personally to their excellence.

Another preparation of the same drug is in the form of effervescent lithium citrate tablets. Each contains 5 grains of lithium citrate. They disintegrate readily in water with brisk effervescence, forming a pleasant draught.

EUMENTHOL TOOTH POWDER.

There is always, commercially speaking, room for a good tooth powder, which in this case has come to us from the Antipodes. Under the name Eumenthol an excellent tooth powder has been produced by Mr. G. Hudson, a well-known chemist, of Ipswich, Australia. The powder is rose pink, finely divided, with a delicate aromatic odour, and in practice will be found to answer its purpose perfectly. We have previously had the pleasure of noticing other preparations of Mr. Hudson's in these columns. The Eumenthol powder is put up in a well-made and convenient metal bottle, with an ingenious device for shaking out the powder.

MEDICAL NEWS IN BRIEF.

The International Anti-Tuberculosis Association.

MANY important practical questions relating to the campaign against tuberculosis are on the programme for discussion at the International Tuberculosis Conference to be held at The Hague, September 6th to 8th. Amongst the speakers will be the following:—On ways of infection—Calmette (Lille), Flich (Philadelphia), Spronck (Utrecht); on specific therapeutics—Brown (Saranac Lake), Maragliano (Genoa); on compulsory notification—Biggs (New York), von Glasenapp (Berlin), Holmboe (Christiania), Raw (Liverpool); on cost of sanatoria—Klebs (Chicago), Lorentzen (Copenhagen), Pannwitz (Berlin), Schmid (Bern), Walsh (Philadelphia); on dispensaries—Dewez (Mons), Kayserling (Berlin), Philip (Edinburgh); on tuberculosis in children—Dietrich (Berlin), Léon Petit (Paris), Schlossmann (Dresden); on education—Heron (London), Pannwitz (Berlin).

The Special Report by the Lunacy Commissioners on Insanity in Ireland.

THIS report, for which the medical profession and the public have waited for a considerable time, has at last been laid before Parliament. It has not, however, as yet been issued to the public in its complete form, and therefore we are only in a position to place before our readers a short summary of the conclusions reached by the inspectors. These are as follows:—

(1) The census statistics of a number of decades past show that while the population of Ireland has continued to decrease, the number of the registered insane has largely increased, and this has given rise to a widespread belief that an actual increase of occurring insanity has taken place in Ireland. Whether or not this belief is well founded it is impossible to state positively, as the available statistics do not afford that precise information on which a definite conclusion can be based. (2) Without venturing to affirm that there has been no increase of occurring insanity, so far as the information at our disposal enables us to form an opinion, we can only conclude that the very great increase which has taken place in the ratio of insanity to the population, is largely due to the accumulation which is taking place in the public asylums; partly to reduction of the population by emigration, and partly to the return of emigrants suffering from mental breakdown, who have either come back voluntarily or have been repatriated by the United States Government. The emigration of the strong and healthy members of the community not alone increases the ratio of the insane who are left behind to the general population, but also lowers the general standard of mental and bodily health by eliminating many of the members of the community who are best fitted to survive and propagate the race. (3) The increase in numbers has taken place mainly amongst the insane supported out of the public rates—the increase amongst the classes who are able to pay, or whose relatives are able to pay for their maintenance in private institutions being small in comparison. (4) The increase of the actual numbers in asylums is principally due:—(*a*) To accumulation, caused by the low and decreasing discharge and death-rates—the latter being much lower than the corresponding rates in England and Wales. (*b*) To gradual absorption into asylums and workhouses of the unregistered insane. (*c*) To the widening of medical opinion as to the degree of insanity which justifies certification and transfer to institutional care. (*d*) To the greater confidence on the part of the poorer classes in the methods of treating the insane in asylums. (*e*) To the increase in the number of asylums, and their greater accessibility. (*f*) To the greater longevity of the population generally, owing to the progress of sanitation. (*g*) To the influx of returned emigrants, who, having broken down mentally abroad, return or are sent back to this country to swell the numbers of the insane. (5) The statistics of insanity in other countries, even more than those of Ireland itself, point to the fact that the Celtic race, notwithstanding their undoubted intellectual gifts, are peculiarly prone to mental disease. (6) While the statistics dealing with the exciting causes of insanity do not exhibit any marked variation from those shown in former reports, it cannot be too prominently pointed out that—next to heredity, which is itself in some cases the direct result of alcoholic excess in the progenitor—intemperance in the use of alcohol continues to head the list. The statistics also show that general paralysis of the insane—a disease at one time almost unknown in Ireland—is now increasing in the more populous urban districts.

We hope to deal with the full report at a later date.

French Mission to West Africa.

THE Paris Society of Geography, under the presidency of M. le Myre de Villers, are organising a French mission to West Africa to study the disease of sleeping sickness. A sum of 200,000f. (£8,000) has already been collected. In addition to the generosity of the members of the Society, notably Prince Roland Bonaparte and Dr. Girard, important contributions have been received from leading French banks, from French houses interested in West African trade, and even from two British commercial houses in French territory. For the choice of the *personnel* of the mission the Pasteur Institute was appealed to. Dr. Roux selected a young officer of the French Medical Corps, Major Martin, who had worked at Saigon and at Lille in the Pasteur Institutes, and had already had an opportunity in Guinea of studying sleeping sickness. He is to be assisted by Dr. Lebeuf, whose scientific attainments have been put to the test in the Congo, by M. Roubaud, a graduate of the Museum, and by a young naturalist, M. Weiss, who has spent some years in Tunis. The mission is to leave Paris in October for Brazzaville, where it will recruit among the natives its interpreters and hospital attendants. After establishing a permanent central laboratory the mission will begin the direct study of the malady up country. Special attention will be paid to the Upper Ugandi region.

Doctor's Action.

AT Leeds Assizes, on August 11th, Mr. Justice Grantham delivered judgment in an action brought by Dr. E. S. Steward, a Harrogate physician, who claimed £130 from a gentleman of the same town, Mr. Alexander C. Weir. The parties were formerly fast friends, and according to counsel, the mining transactions between them were curious and complicated. The defendant had been engaged in company promoting, and lived in good style at Harrogate. The defendant said that he knew of a very excellent investment, and, as a great favour, he would let plaintiff have some shares which would yield a very considerable profit. The plaintiff took a hundred fully-paid shares in the "Anglo-Transvaal Mines (Limited)," which were to be pooled. The plaintiff, however, could get no scrip recording the transfer, and the defendant denied the contract to deliver the shares. A witness said that the pooling managers did not think themselves justified in selling the shares until they had some information they were seeking to obtain. The defendant, in his evidence, said he explained the pooling arrangement to the plaintiff

several times. The arrangement was that the shares were not to be sold for under 30s, before April 1st. Mr. Justice Grantham gave judgment for the plaintiff for the full amount claimed, and costs. He said that the defendant had purported to sell an article which had no existence, and there had, therefore, been a total failure of consideration for the payment of the £130. The plaintiff must have a verdict. A stay of execution was refused.

Plague Precautions in Mysore.

At the present moment a systematic campaign of rat destruction is being carried on in Mysore under the express orders of Mr. Madhava Rao, the Minister of that State. Colonel Smyth, the Sanitary Commissioner, has directed in person the operations in Mysore City, which is the place of residence of the Maharajah. The people have manifested a welcome desire to aid the authorities, as they are now convinced of the close connection between rats and plague. The members of the Jain sects who are opposed to the taking of life in any form, are alone retarding the measures now in course of execution; but it is hoped that the influence of Mr. Madhava Rao will avail to overcome their objections, so far, at least, as to induce them to remain passive while their houses are purged of vermin.

Friendly Societies.

On July 27th, the Clay Cross and District Friendly Societies' Council listened to an interesting and instructive address on "Medical Associations," given by Mr. Bradwell (editor of the *Equalised Order of Druids' Magazine*), of Sheffield. Dealing exhaustively with the subject, he first of all gave caution against certain errors in the formation of such societies, and care in forming such associations. It had been stated that three grades of drugs were used by the medical men: First, for private patients; second, for club members; and third, for those dependent entirely on the parish. By medical associations the club members received only first-class medicines, and none other were allowed to be purchased; the firms supplying drugs having to warrant them as the best on the market. The result was that members were speedily restored to health, especially as, coupled with pure medicine, was the thorough and entire attention of the doctor. The courts and lodges benefited materially, as the funds were thus saved. Medical societies provided also for members' wives and children at reasonable rates, and thus obviated what in large towns was severely felt by the poorer classes—the inability to pay at ordinary rate for medical service. He said it had been stated that only poorly-qualified men could be induced to serve such associations. That was absolutely false. In Sheffield the two gentlemen who served their association were each an M.R.C.S., L.R.C.P., and one of them had also other special qualifications. They might rely upon it that when they were ready for them they would be able to obtain gentlemen who would serve them honourably and successfully. The financial difficulties were by no means great, and the prospects of increase in number and magnitude of such societies were very bright.

Midwife Sentenced.

Ann Taylor (64), midwife, was indicted on a charge of having, at St. Helens, on June 9th, feloniously killed and slain Ruth Dinah Gibson. Mr. Lias prosecuted, and Mr. H. L. Riley defended. The evidence for the prosecution was that the deceased was the wife of James Gibson, a collier, and that the prisoner was a certificated midwife. The prisoner attended the deceased on her premature confinement. Twins were born, and both died two days later. It was alleged that the prisoner should have sent for a medical man and waited until his arrival, but this she failed to do. It was also alleged that she was under the influence of drink, that she unskilfully performed a delicate and dangerous operation on the deceased, which ought to have been done by a surgeon, and that she ceased attendance on the deceased earlier than was allowed by the regulations. Mrs. Gibson's death was due to septic poisoning, which was found upon a *post-mortem* examination to have been due to improper attention. The witnesses for the prosecution included Dr. Buchan, Medical Officer of Health for St. Helens.

The prisoner, giving evidence on her own behalf, said she was a widow, and had been a midwife for thirty-four years. Mrs. Gibson was the only patient that had died under her treatment, and there had been previously no complaint against her. She denied having been under the influence of drink at the time in question; she had not had any drink for about twelve months. She also denied having treated deceased improperly. She twice advised the deceased to get a doctor. Questioned by the judge, the prisoner said at first that she had a clinical thermometer, but afterwards admitted that she did not know what a clinical thermometer was. What she meant was a smal bottle of disinfectant.

The jury found the prisoner guilty, and strongly recommended her to mercy on account of her age. His lordship said he would bear in mind the prisoner's age, the fact that she was a relic of an old system, and other favourable circumstances. She must go to prison for three months in the second division.

Germany and Tuberculosis.

From 1901 to 1905 the insurance companies of Germany have expended nearly £2,000,000 in fighting the scourge. This outlay included twenty-six sanatoria, with 2,111 beds, for women, and ten sanatoria, with 541 beds; for children, all these being due to the suggestion of the German Empress.

Illness in Camp.

Some alarm has been occasioned in the military camp at Fleetwood by the sudden outbreak of a mild form of typhoid among the officers of the 3rd North Lancashire. The cause of the outbreak has not been ascertained yet, but a strict investigation is being conducted by Captain Rodgers and Major Pearce, of the Royal Army Medical Corps, who have been sent down from Chester. Bacteriological examinations of food and of the water supply are being carried on, and the evidence, it is stated, points to the latter being contaminated in some way. In consequence of the sickness the officers' mess has been closed.

List of Mortality.

According to the Registrar-General's Report for the week ending August 4th, the deaths registered last week in seventy-six great towns of England and Wales corresponded to an annual rate of 13·8 per 1,000 of their aggregate population, which is estimated at 15,818,360 persons in the middle of this year. In the preceding three weeks the rates had been 11·7, 12·0, and 12·6. Table 1 of this return shows, for the several towns, the death-rates in each of the last four weeks; it also shows for the week ended last Saturday the births, the deaths from several causes, and the death-rates from certain epidemic diseases. Measured by last week's mortality, the highest annual death-rates per 1,000 living were:—From all causes, 19·0 in Newport (Mon), 19·7 in South Shields, 19·8 in Stockton-on-Tees, 20·3 in Rochdale, 20·5 in Wigan, 21·2 in Coventry, 21·4 in Huddersfield, and 26·9 in Bootle; from measles, 2·0 in Salford, 2·5 in Burnley, and 3·8 in Huddersfield; from whooping-cough, 1·3 in Portsmouth and in Birkenhead; and from diarrhœa, 3·0 in Leeds, 3·1 in Birkenhead, 3·3 in Walsall, 3·5 in West Ham and in Merthyr Tydfil, 4·2 in Wigan, 4·4 in Leyton and in Aston Manor, and 5·5. in Bootle. No death from small-pox was registered in any of the seventy-six towns. In London 2,576 births and 1,272 deaths were registered. Allowing for increase of population, the births were 22 above and the deaths 12 below the average numbers in the corresponding weeks of the previous four years. The annual death-rate from all causes, which had been 11·8, 11·6, and 11·7 per 1,000 in the preceding three weeks, rose last week to 14·0. The death-rate in the four weeks ended last Saturday averaged 12·3 per 1,000, being 1·9 per 1,000 below the mean rate in the corresponding periods of the four years, 1902-5.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS. ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT MEDICAL LITERATURE.

Alcoholic Dextrins and Marasmus.—Symes (*Brit. Journ. of Children's Diseases*, July, 1906) discusses the value of alcoholic dextrins, given in the form of Guinness's stout, in the treatment of some severe forms of marasmus in children. Symes has found that in a certain proportion of children a condition of marasmus develops as a result of the early administration of improper food, which defies all methods of artificial feeding. He illustrates three such cases in which various artificial foods, as well as modifications of cows and asses' milk, were tried but still the child continued to vomit, and decline in weight. In each of these cases the addition of porter to the child's food was followed by a marked and steady improvement in weight and in the general condition of the little patient. Approximately 1 oz. of stout is equivalent in alcoholic value to 1 dr. of brandy, and half an ounce can be given to a marasmic infant every four hours with the greatest safety. Symes orders the stout in the following way: Guinness' XXX stout ½ oz., hot water ½ oz., cream ½ to 1 dr., fresh beef juice 2 to 3 dr., sugar—every four hours. In no case in which the stout was used did it intoxicate the child or make him drowsy, and no hiccough, flatulence or diarrhœa was observed. The stout itself may be described as an extract of malt containing abundant carbohydrates in the form of dextrins, no starch, no sugar, and a small quantity of alcohol averaging about five per cent.

Enteric Fever with Spontaneous Rupture of the Spleen.—West and Dudding (*The R.A.M.C. Journ.*, Aug., 1906), describe a case in which the death of the patient resulted from this rare complication. On admission to hospital the patient complained of having been ill for two days, his temperature was 101·4° F., there were no rose spots on the abdomen and no marked enlargement of the spleen was observed. Four days after admission to hospital rose spots were first seen, but even then the splenic dulness was not marked. Three days later he complained of sudden and severe pain in the abdomen and vomited. He rapidly became very collapsed, somewhat restless, with weak and rapid pulse, and the abdomen was tender, distended and tympanitic, and the liver dulness diminished. Perforation of the intestine being diagnosed, the patient's abdomen was opened three hours later. The lower part of the abdomen was found to be filled with blood by which the intestines were floated up against the anterior abdominal wall, but there was no air in the abdominal cavity. Careful search was made for perforation of the intestine, but none was found and the patient's condition was so bad that the abdomen was closed, the cavity having been washed out with very hot saline solution. The man died shortly after. On *post mortem* examination the spleen was found to be very large and to have a rupture about three inches long on the diaphragmatic surface, the capsule being extensively separated by blood clot. Well-marked enteric ulcers were found in the intestine, and the mesenteric glands were enlarged. The other organs were healthy. K

The Practical Significance of a Trace of Albumen in the Urine.—Tunis (*The American Journ. of the Med. Sciences*, July, 1906) discusses this important question, and reviews the opinions expressed upon it by a number of representative physicians. "By a trace of albumen is meant such a trace of albuminoid substance as can be detected by means of the heat and nitric acid test or by Roberts' solution properly applied—such a trace not to be accompanied by any tube casts of pathological significance *per se* in an otherwise perfectly healthy man." Tunis quotes the views of various writers on this subject and finds in them little or no agreement. In order to secure a consensus of present day opinions, a letter asking the following questions was sent to about twenty representative physicians: (1) Is there such a condition as physiological albuminuria? (2) Have you had under your observation any case or cases where a trace of albumen has been present in the urine for ten years or longer in an apparently healthy man? (3) Do you not think that the mortality among cases showing continuously a trace of albumen is much greater than among an equal number of healthy lives during the same period? The answers received varied a good deal, but that to the third question was in the affirmative in all but two instances. From the evidence at his disposal Tunis draws the following conclusions: (1) From any point of view the term "physiological albuminuria" is almost universally regarded as misleading, unsatisfactory, and inadequate. (2) As long as albumen is a constituent of the urine the individual voiding it cannot be regarded as normal. (3) The mortality among such persons must necessarily be higher than among an equal number of individuals who do not show this phenomenon. (4) The actual mortality rate among this class can best be approximated by a comparison of the records of half-a-dozen of the largest life insurance companies (dealing with hundreds of thousands of cases) over a period of twenty years at the least. (5) The prompt means of discriminating between the transient forms of albuminuria and those of real clinical significance may be found in some such therapeutic test as that of calcium lactate, rather than by any further developments in the chemistry of the urine. (6) Experience proves that "a faint trace of albumen" is often of greater significance than "a decided trace" by unexpectedly directing attention to the finding of casts of pathological importance, which might otherwise have been easily overlooked. (7) For practical purposes the heat and nitric acid test for albumen is the best one, and the careful use of Roberts' solution the most satisfactory control test in doubtful cases. (8) For the proper diagnosis and prognosis too much stress cannot be laid on a thorough consideration of the clinical conditions as a whole. K.

Cancrum Oris.—Telford (*The Med. Chronicle*, July, 1906) describes a severe case of this disease in a child æt. 7. Besides the usual surgical treatment of free excision of the diseased parts and swabbing with pure carbolic acid, the child was given considerable doses of antidiphtheritic serum. The diphtheria bacillus does not appear to have been isolated from the patient, but the nurse who attended the case fell sick with an acutely injected throat from which, by culture, the diphtheria bacillus was obtained. The child made an excellent recovery, and was discharged from the hospital ten days after admission. K.

"Memorandum" Regarding Antityphoid Inoculation.—Captain Harrison (*Journ. R.A.M.C.*, July, 1906) points out that the vaccine now in use is modified in accordance with experiments made during the last year and a half. The dose which is recommended at present is a quantity containing 500 million bacteria for the first dose and a 1,000 million for the second dose. These are generally contained in 1 cc. and 2 cc. of fluid respectively (18 and 36 minims). This vaccine was used for the 17th Lancers, and the results of the epidemic among this regiment at Meerut have all the force of a

laboratory experiment, since the men who formed the test were all under the same conditions throughout. The only case among the inoculated men in the Meerut epidemic occurred in a man who had refused the second dose. The clinical effects of the inoculation are much milder than was the case with the old vaccine, As a rule, all symptoms have disappeared thirty hours after inoculation. After the second dose the local reaction comes on, and disappears more quickly than after the first, and as a rule there is but little general reaction with the second dose. Re-inoculation is advised once in two years. K.

Meniere's Disease and Meniere's Sympton.—Amberg (*American Journ. Med. Sciences*, July, 1906) discusses the advisability of giving up this nomenclature in the description of ear diseases. Amberg considers that the triad, hardness of hearing, vertigo and tinnitus which constitute the functional disturbances observed in the so-called Meniere's disease also occur in numerous affections which are not based on the pathological finding as described by Meniere in his historical case. The introduction of a more definite nomenclature would be of importance from a physiological, a pathological and a clinical standpoint and would be in accordance with the procedure in other departments of medicine. K.

Leubartz Treatment of Gastric Ulcer.——Haberman (*Med. Record*, New York, June 16th, 1906) gives the following treatment of gastric ulcer: Absolute rest in bed for at least four weeks; avoidance of all mental excitement; the almost continual use of an icebag over the stomach for two weeks; the administration of between 200 and 300 cc., of iced milk, given in spoonsful, and from two to four beaten eggs; the administration for ten days of 2 grs. of Bismuth subnit. at a dose. The eggs are beaten up entire, with a little sugar, and the dish containing them is placed in a receptacle filled with ice; sometimes a little wine is added. This food at once binds the supersecretive acid, mitigates the pain, and causes the vomiting to cease. After a few days some raw chopped meat is given. In the third week quite a mixed diet is allowable. D.

Case of Veronal Poisoning.—Germann (*Journ. Amer. Assoc.*, June 30th, 1906) records a case of veronal poisoning in a young, healthy man, æt 22, who took 200 grains of the drug. The following points were noted: Persistent coma for seventy-nine hours, pulse remained quiet and steady till very near the end; gradual rise of temperature to 108·4 *ante mortem*; cyanosis appeared only very late. *Post mortem* was found intense cerebral congestion and marked congestion of organs, especially the stomach. D.

Mercurial Treatment by Way of the Rectum.—Audry (*Annales de Dermatol et de Typh.*, Paris, 1906), has given this method of mercurial treatment thorough trial in forty-eight cases, and has been much pleased with the results. He gives the details of thirty typical cases, all showing that mercurial medication by way of the rectum is perfectly tolerated and is as effectual as by other technics. He administers the mercury in the form of suppositories made of cocoa butter, and a liquid preparation of metallic mercury in olive oil and vaseline; each suppository contains 2 cc. of mercury. One suppository is used every evening for a month; they are then omitted for four or five days, and then again given. One child of 3 was thus treated with 100 suppositories during four months, each suppository representing 1·5 cc. of mercury. No local or general inconveniences of any kind were observed. The effect seems to be the same as from other methods of mercurial treatment. In some control cases the course of the lesions under this and parallel mercurial treatment by the ordinary technics seemed to be identical. The action of the rectal medication was particularly prompt and certain in case of lesions in the anogenital region and in the mouth and throat. D.

Enterogenic Cyanosis.—Van der den Bergh and Gruterinck (*Indian Med. Record*, June 13th, 1906), describe six cases of cyanosis dependent on the absorption of toxic products from the intestine. The cases could be divided into two distinct types. In one set the blood gave the spectrum and chemical properties of salphohæmoglobin, while in the other genuine methæmoglobinemia was present. In the cases of the former class the condition was promptly relieved by a thorough course of intestinal purgation, and in the other the cyanosis would disappear after one or two days of rigid milk diet, to return again when vegetables were added to the regimen. After considerable time had been spent in experimentation, it was discovered that the cause of the reduction of the hæmoglobin was the presence in the blood of nitrites, probably dependent on their increased production in the diseased intestinal canal. D.

Diphtheria Antitoxin in Chorea.—Hamilton (*Med. Record*, New York, June 16th, 1906) saw a case of chorea in a boy, æt. 15, who had suffered from an aggravated form of chorea for several months. He gave the boy full doses of antitoxin, after which the chorea symptoms disappeared and did not return. Recently he attended a young man who suffered from chorea following rheumatism. Delirium developed into a violent mania, and it was plain that unless relief was afforded, death was not far distant. Three thousand units of diphtheritic antitoxin were administered, after which the chroreic symptoms were so much relieved that all restraint was removed. After two more doses, the first of 1,500 and the second of 2,000 units of antitoxin, all irregluar muscular symptoms subsided and have not yet returned. D.

Picric Acid Poisoning.—E. J. Eliot (*Lancet*, April 28th) calls attention to an important case of picric acid poisoning, which occurred in a girl of 14, burnt about both arms, second and third degree, who was treated by the application of a saturated solution of picric acid to the raw surface every second day. All went well for seven days, when the symptoms of poisoning first showed themselves. They were:—(1) Intense sickness, tongue dry and furred; (2) temperature, previously normal, rose to 102, pulse to 154; (3) conjunctiva became yellow and skin generally showed an icteric tint; (4) a bright red papular rash over almost the entire body; (5) the urine bright red in colour, with a greenish shimmer on the surface. The application of the picric acid was stopped and at once all these symptoms disappeared. In most of the recorded cases of picric acid poisoning, all the above symptoms have been present, but in several cases diarrhœa also occurred. The rash may easily be mistaken for measles, but it spared the face, and was especially well marked in those parts of the body in contact with each other, and also where subjected to pressure. G.

The Staining of Blood Platelets.—So varying are the results, even with the best blood-stains, in the appearance of blood-platelets, that many observers fail to distinguish platelets from artefacts. A trustworthy method of staining them opens up, therefore, almost a new field of study. Wright (*Boston Med. and Surg. Journal*, July 12th, 1906) recommends a method by which he claims to have obtained excellent results. Perfectly fresh tissue, *e.g.*, the spleen of a young kitten, should be fixed in methyl alcohol, dehydrated by acetone, cleared by xylol, and imbedded in paraffin. Sections should then be cut, and stained by Wright's method for blood smears. The method is as follows: Cover the film or section with Wright's fluid and add an equal quantity of water; after ten minutes rinse in water; dip in 1 in 5,000 solution of sodium hydrate for five seconds; wash in water; dehydrate with acetone; clear with oil of turpentine; mount in turpentine colophonium. Wright regards the acetone and turpentine as essential to the process, as he knows no other dehydrating and clearing agents which do not destroy the characteristic staining of the platelets. R.

NOTICES TO CORRESPONDENTS, &c.

☞ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to 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 proofs.

CONTRIBUTORS are kindly requested to send their communications if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

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.

F. (Bakewell).—By the Factory Act an injured workman cannot be compelled to submit to a suggested treatment prior to the final assessment of the compensation due to him as the result of the accident. Had your patient allowed an operation, and died from it, the employer might have repudiated all liability.

A SKELETON ODE.

O skeleton within the big show window!
How oft I envy you your bony quiet!
You've no more aches or pains or worries,
And now you never have to watch your diet.

"Neuralagy" never tries to reach you;
The rage of "rheumatiz" you no more feel;
You're never scared by reading of the microbes,
And you've no fear of any surgeon's steel.

—*The Doctor*, America.

M.D.—(Tonbridge).—There is a sanatorium exclusively for ladies at Ebersteinburg, half-an-hour from Baden-Baden. We think a Dr. Rumpf is at the head of it.

POPULAR IDEAS.

OVERHEARD IN THE STREET.

OLD WOMAN: "I persuaded my man to go to the vet.; 'e's a nice old gent."

FRIEND: "Why didn't he go to the young man at the 'Spensary?"

OLD WOMAN: "'Cos, as I said, an ole vet.'s better'n a young doctor, any day."

LECTURER.—Certainly the course of lectures should be useful. There are so many ambulance members who carry directions in their pockets and not in their heads. Only this week we saw a policeman forcing an epileptic into a sitting posture and trying to pour brandy down her throat.

EPHIDROSIS.—The advice given in popular papers of the type you quote is beneath contempt as a rule. But it is interesting to notice that of late years the ideas of the writers are a little less crude than they were. The suggestion "Not to mingle with crowds when overtired" as a suggestion for avoiding pneumonia is, as you remark, characteristic of this kind of writing.

BARON MUNCHAUSEN AND THE COLLEGE OF PHYSICIANS.

WE quote the following from the orginal edition of "The Travels of Baron Munchausen" for comparison with the edition in the possession of a Liverpool correspondent referred to in our last:—"On the 30th Sept., when the College of Physicians chose their annual officers and dined sumptuously together, I filled my balloon, brought it over the dome of their building, clapped the sling round the golden ball at the top, fastening the other end of it to the balloon, and immediately ascended with the whole college to an immense height, where I kept them upwards of three months. You will naturally inquire what they did for such a length of time? To this I answer, had I kept them suspended twice the time, they would have experienced no inconvenience on that account, so amply, or rather extravagantly, had they spread their table for that day's feasting."

DR. H. (Leeds).—Thank you for MS. sent in, but it is a little one-sided. There are many provisions made for the safety and health of employés which are never used by them. A large manufacturer said the other day he constantly had to put up "fool protectors," owing to the deliberate carelessness of his men.

LONDON M.D.—We would strongly dissuade you from going either to Johannesburg or Durban. There is no lack of doctors there, but only lack of money.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, AUGUST 15th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—10 a.m.: Diseases of the Throat, Nose, and Ear. Dr. Saunders: Diseases of Children. 2 p.m.: Medical and Surgical Clinics. 2.30 p.m.: X-Rays. Operations.

THURSDAY, AUGUST 16th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—2 p.m.: Medical and Surgical Clinics. 2.30 p.m.: X-Rays. Operations. Mr. Dunn: Diseases of the Eye. 4 p.m.: Lecture:—Mr. Dunn: Demonstration on Selected Eye Cases.

FRIDAY, AUGUST 17th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—2 p.m.: Diseases of the Throat, Nose, and Ear. Medical and Surgical Clinics. 2.30 p.m.: X-Rays. Operations. Dr. Abraham: Diseases of the Skin. 5 p.m.: Dr. Ball: Some Points in Middle Ear Suppuration (with lantern slides).

SATURDAY, AUGUST 18th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—10 a.m.: Diseases of the Throat, Nose, and Ear. 2 p.m.: Medical and Surgical Clinics. 2.30 p.m.: X-Rays. Operations.

Vacancies.

Liverpool Infectious Diseases Hospital.—Assistant Resident Medical Officer. Salary £120 per annum, with board, washing, and lodging at the Hospital. Applications to the Port Sanitary and Hospitals Committee, Town Clerk, Municipal Offices, Liverpool.

Worcester County and City Asylum.—Third Assistant Medical Officer. Salary £130 per annum, with board, lodging, and washing. Applications to the Medical Superintendent, Powick, Worcester.

Newcastle-on-Tyne Dispensary.—Visiting Medical Assistant. Salary £160 per annum. Applications to the Honorary Secretary, Joseph Carr, Chartered Accountant, 26 Mosley Street, Newcastle-on-Tyne.

Egyptian Government.—Ministry of Education.—Professor of Midwifery and Gynæcology. Salary £400 a year, with private practice. Applications to the Director, School of Medicine, Cairo, Egypt.

Egyptian Government.—Ministry of Education.—Medical Tutor and Registrar to Kasr-El-Ainy Hospital. Salary £400 a year. No private practice. Applications to the Director, School of Medicine, Cairo, Egypt.

Fermanagh County Infirmary, Enniskillen.—House Surgeon. Salary £52 per annum. Applications to C. Wilson, Secretary.

County Borough of St. Helens.—Lady Assistant Medical Officer. Salary £160 per annum. Applications to the Chairman of the Health Committee, Town Hall, St. Helens.

Northern Infirmary, Inverness.—House Surgeon. Salary £100 per annum, with board, &c. Applications to Mr. Duncan Shaw, W.S., Inverness.

County Asylum, Dorchester.—Junior Assistant Medical Officer. Salary £140 per annum, with board, lodging, &c. Applications to the Medical Superintendent.

Chesterfield and North Derbyshire Hospital and Dispensary.—Senior House Surgeon. Salary £120 per year, with board, apartments and laundress. Applications to the Secretary at the Hospital.

Somerset and Bath Asylum, Cotford, Taunton.—Assistant Medical Officer. Salary £140 per annum, with furnished apartments, board, fuel, lighting, washing, and attendance. Applications to the Medical Superintendent.

Preston Royal Infirmary.—Resident Medical and Surgical Officer. Salary £130 per annum, with board, residence, attendance, and washing. Applications to Mr. Walter Davies, Secretary, 5 Winckley Street, Preston.

York Dispensary.—Resident Medical Officer. Salary £120 a year, with board, lodging, and attendance. Applications to W. Drape, Esq., De Grey House, York.

Appointments.

HUGHES, PERCY, T., M.B., C.M.Edin., D.P.H., Medical Superintendent to the Worcester County Asylum, Barnsley Hall, Bromsgrove.

MACLEAN, ALICE W., M.B., Ch.B.Glasg., House Surgeon at the Chorlton-upon-Medlock Dispensary, Manchester.

PHILLIPS, H. J., M.R.C.S., L.R.C.P.Lond., Assistant Medical Officer to the London Open-air Sanatorium, Pinewood, Wokingham, Berks.

Births.

CALVERLEY.—On Aug. 11th, at 21 Earl's Avenue, Folkestone, the wife of J. E. J. Calverley, C.M.G., M.D., &c., &c., of a son.

FLEMING.—On Aug. 7th, at 10 Chester Street, Edinburgh, the wife of Robert A. Fleming, M.D., F.R.C.P.E., of a son.

GIDEON.—On Aug. 7th, at Bridge House, Canterbury Road, Hatcham, the wife of G. V. M. Gideon, M.R.C.S., L.R.C.P.Lond., L.S.A., of a son.

HOLMES.—On Aug. 6th, at Barton Abbey, Oxfordshire, the wife of A. Hewston Holmes, M.D., of a son.

MOON.—On Aug. 5th, at High Beach, Victoria Parade, Broadstairs, the wife of E. G. Moon, M.R.C.S., L.R.C.P., of a daughter.

SLADEN.—On Aug. 7th, at 2 Talbot Road, Highgate, the wife of Reginald J. Lambart Sladen, M.R.C.S., L.R.C.P., of a son.

Deaths.

KALAPESI.—On July 16th, at Frere Road, Fort, Bombay, of tuberculosis, Dr. R. M. Kalapesi, M.B.Lond., D.T.M.Camb., M.R.C.S., &c., in his 37th year.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIII. WEDNESDAY, AUGUST 22, 1906. No. 8.

NOTES AND COMMENTS.

The Townshend Case.

A little sensationalism has been infused into the dead season by the inquisition into the state of Lord Townshend's mind, and most people who take the trouble to read their papers are well fortified in the facts and consider themselves competent to pass a judgment on them. From the medical point of view the case presented many features of interest as regards both the scientific and medico-legal sides. The Marquis was one of those amiable, puny, feeble-minded creatures who are met with frequently in the humble walks of life, and after being kicked at school and buffeted by the world gradually find a niche in a benevolent relative's home and do nobody any harm. Their mental classification is puzzling, for they do not fit exactly into any of the alienists' pigeon-holes, but so long as they have a limited range of action they do not need certification to protect either themselves or society. They may be regarded as sane or insane as circumstances require, sane when harmless and insane when actually harmful. The Marquis was very properly certified as insane when he was found to be wasting his money on a lot of undesirable parasites, and now that he will have a committee responsible to the Lord Chancellor for his property, he may with fair safety be allowed freedom of personal action.

Insanity and the House of Lords.

Mr. Swift MacNeill might be trusted not to allow so favourable an opportunity to pass without having a dig at the hereditary chamber. He has had it in *The Times*, and a justifiable dig it is. He points out that under the Bankruptcy Act, 1883, a peer who is bankrupt is debarred from sitting in the House of Lords, and that in a Bill introduced by Lord Salisbury an attempt was made to restrain members of that House guilty of moral obliquity from taking part in the affairs of the nation. But there is nothing to prevent a peer who is an idiot, an imbecile, or a lunatic from speaking and voting in the upper chamber, and thus we arrive at the extraordinary result that a man who is acknowledged to be incapable of looking after his own affairs is considered by the Legislature a fit person to aid in the revision of the decrees of the people's representatives. The supporters of the hereditary principle in politics will have to take care lest they find the Marquis Townshend taking his seat in the House of Lords and voting on the Education Bill. Such a paradoxical incident would produce the *reductio ad absurdum* which kills more quickly than abuse.

Kissing the Book.

From a correspondence on the subject now going on in *The Times* it is evident that what may be called sanitary reform in the method of administering the oath in the courts of law makes but slow progress, mainly owing to the prejudice or indifference of judges and magistrates. It is stated that the books in some courts are too filthy for description, and that many persons putting their lips to them would never be allowed to use the same article as others in any place where the most common sanitary precautions were taken. In spite of this, many judges and magistrates still show so much reluctance to accept the alternative of swearing by raising the arm that witnesses are often constrained to undergo a loathsome ordeal which they detest and from which they have a right to escape. Judge Emden has shown an example in this matter. Twelve years ago he caused notices to be placed in his courts drawing the attention of the public to the fact that they were entitled to be sworn with uplifted hand in the Scotch fashion, and during all this time nearly every person has elected to take the oath in that way. It is satisfactory to add that Judge Emden's examplehas been now followed at Lambeth Police Court. Within the past few days instructions have been given that witnesses are to be offered the option of being sworn with uplifted hand. So far, it is stated, the great majority of witnesses have availed themselves of this offer. It seems a pity that no high authority exists having the power to insist upon the carrying out of this reform throughout all the courts of every grade within the kingdom.

The Peculiar People.

In our leading articles and in contributions by correspondents after the recent trial for manslaughter in the Christian Science case, the law as to the responsibility of persons in charge of the sick with regard to the summoning of medical assistance was explained with sufficient clearness. It is evidently incumbent upon parents and guardians of children, and upon those who have the charge of patients mentally irresponsible—idiots, imbeciles or lunatics—to call in medical help when needed;

and if a death ensues owing to neglect of this duty a charge of manslaughter may be brought forward. In an inquest on such a case everything turns upon the question—Could life have been saved or prolonged by medical science? Doubt upon this point led to the verdict of "Death from natural causes" in the case investigated at the West Ham Coroner's Court on Thursday last. A child, age six months, had died from diarrhœa. No medical attendance had been procured by the parents—members of the "Peculiar People"—but the usual rites of their sect had been performed. Dr. Angus Kennedy deposed that death was due to epidemic diarrhœa, and that, whilst he thought that medical attention would have relieved the child, he was not prepared to declare that its life could certainly have been saved. He added that a great many children were dying from summer diarrhœa at the present time, whether medical aid was called or not, and that the death-rate of London had increased 4 per cent. during the last three weeks from this cause alone. Dr. Angus Kennedy's evidence no doubt determined the character of the verdict, but the fact that the jury having added that they considered a medical man should have been called in made it obvious how near they had come to pronouncement of a less merciful judgment.

LEADING ARTICLE.

UNIVERSITY EDUCATION IN IRELAND.

THE correspondence which has been provoked by the somewhat premature divulgement of schemes for the reform of University education in Ireland, still rages in the daily papers, and has led to the publication of much interesting information. Briefly, the present position is as follows:—The Junior Fellows of Trinity College, many of the professors, and a considerable body of representative Catholic laity desire a scheme of mixed education in Trinity College, since they appreciate the evil results which must flow from the division of the youth of Ireland into two hostile camps. The Catholic hierarchy refuses to accept such a scheme, but professes itself willing to accept either a second college in Dublin University, a new Catholic University, or a college in the Royal University, any or all of which necessarily meaning the establishment of a sectarian as opposed to a non-sectarian college. Trinity College refuses to agree to the establishment of a second college in the University of Dublin, with which she is indissolubly connected, presumably on the grounds that, as was shown by the Royal Commission on University Education in 1901-3, the thrusting of a sectarian college into an institution which had up to that time been non-sectarian had led to many ills. Letters from members of the Gaelic League show that not alone must the new or reformed college, whichever it is to be, be acceptable to Catholics, but it "must be made thoroughly Gaelic and national in character." And the Corporation of Cashel give vent to the hope in regard to those members of the Catholic laity who have advocated the re-casting of Trinity College that "each of these deserters will be adequately dealt with by all honest Catholics." On the other hand, the *Church of Ireland Gazette* strives to emphasise as a fact that Trinity College is a Protestant institution, and says that it is for the "Church and Churchmen to consider . . . . whether they can sanction . . . . this proposed transmogrification of their Alma Mater." We do not envy the Commissioners the task before them, nor do we covet their laurels which the result of their labours will bring. If the wishes of what may be termed the moderate party, who seek for mixed education, are to be thrown aside in order that Trinity College may be converted into a Protestant institution and a new Catholic institution created; if the cries of the Gaelic League for an institution which will be "national" are to be answered; if the demands of domestic economy and the warnings of past experience are to be neglected, then the laurels of the Commissioners will not be valued by posterity. If, on the other hand, they, as men of business, shut their ears to the charms of the sectarian and the politician and attend to the duty for which they have been summoned, they will receive the unanimous condemnation of all parties of extremists, and the result of their labours will probably be repudiated by the Government which appointed them. We have referred to the demands of domestic economy and the warnings of past experience, and perhaps we should explain our meaning. With regard to the former, it is simply this:—Ireland, with a diminishing population, and an extreme necessity for obtaining the best value for her money, is seeking to incur the expenses of a double, treble or quadruple university establishment, not in order that she may receive greater educational advantages, but that she may indulge in the privileges of having for each man a teacher of his own particular religious and political colour. Carry on such a scheme a little further and Ireland will be a grand country for the educationalist in search of employment. There will be numerous posts and no pupils. With regard to experience, our allusion is to the increasing lunacy for which—if a bull be allowed—no one can find a cause, yet the origin of which everyone knows. Is the establishment of religious and political universities a good panacea for a country already driven to the borders of insanity by religious and political excitement? *Similia similibus curantur?* In conclusion, we desire to quote, with slight alteration, the concluding sentence of a well-reasoned letter which Mr. Edward Gwynne has contributed to the general discussion: The interests of the students in a mixed college will be safe so long as they are in the hands of men who have won their position by their merits, and whose first object will be the welfare of their university, not that of a particular Church. Perhaps we may also add, the interests of the nation will be neglected when the education of its sons is placed in the hands of the politician.

NOTES ON CURRENT TOPICS.

Insurance against Doctors' Bills.

From time to time an enterprising newspaper or an association of some kind brings out some scheme for supplying people with doctors, but, as our readers are well aware, these schemes are nearly always open to grave objection. Either the medical profession is exploited for the benefit of the association, or attempts are made to wean patients away from their own doctors, or some particular doctor is forced on subscribers whether they will or no. So many and ingenious are the ways by which such evil designs are foisted on the public that one begins naturally to distrust everything presented to our notice. Our attention, however, has recently been drawn to a new policy issued by the Central Insurance Company which we have carefully examined, and in so far as it goes it seems to us not only to be free from objection but positively to cut the Gordian knot that so many have hacked at. Under this policy the assured by paying a certain addition to his premium gains the benefit of having his doctor's bill paid when suffering from the accidents and diseases covered by the policy. At the end of the illness his own doctor sends in his bill to the patient, who presents it to the company and receives a cheque. We do not pretend to have examined into the basis in which the requisite calculations are made, but the company are satisfied that they are in a sufficiently strong position to undertake their responsibilities under this head, and we can only add that if a workable scheme can be produced by which medical attendance on all illnesses could be covered by premiums paid during times of health, the medical profession would warmly welcome it. It happens from the nature of circumstances that the doctor's bill is incurred when the patient is least able to meet it, and too often the doctor is either only paid after long delay, or not paid at all. If, therefore, a patient can insure against his liabilities to his doctor, no one would be better satisfied to have such patients than he who has attended many of the improvident and reckless.

The Struggle for Existence.

There was a pathetic advertisement in the *Times* the other day, and we are glad to see that it is already receiving quotation in various journals. It ran :

AN EAST-END (London) MEDICAL MAN, B.A., Cantab., who has never had a day's holiday or a Sunday's rest since he has been in practice, and who has not sufficient capital to purchase a more comfortable living, would like to change his profession. He has taken honours in Science, so judges himself capable of filling a Post as ANALYTICAL CHEMIST. Having good credentials and references, he hopes that manufacturing firms, &c., will give his advertisement their consideration.

Those who are in a position to judge know only too well that the East End (London) medical man is typical of a large class. A man may be well educated at a university, he may be competent in his profession, he may be diligent and industrious, and yet through want of capital and friends he may be reduced to drudgery such as the worker in the factory and the domestic servant have no idea of. If the man who has never had a day's holiday or a Sunday's rest were of the "working classes," he and his friends would be in a state of justifiable rebellion ; but being an educated gentleman he has to grin and bear it. We cordially hope a firm of manufacturing chemists may be able to help our colleague.

Lunacy Procedure.

One cannot be altogether surprised that the papers during the last few days are full of comments on the certification of the insane and on that happy hunting-ground, the profit accruing from private asylums. The lunacy laws in theory provide adequate safeguards against malpraxis and mistaken certification by compelling the signatures of two independent medical men to a certificate, by providing for the co-operation of a magistrate, and by the notification to the Commissioners in Lunacy of all fresh certifications. Moreover we believe strongly that the power placed in the hands of medical men is used in as honourable fashion as it would be impossible to obtain in any walk or rank of life. The evidence that people are maliciously certified as insane, at least for the last fifty years, is conspicuously lacking, and critics are always discreetly silent on the subject of actual conspiracy. In one point, however, they are right, and that is in insisting on the insecurity of patients who may have been mistakenly certified and who are dependent on the visit of the commissioners to establish their sanity. Far from being the fault of the commissioners themselves, this unfortunate possibility is due to the utter inadequacy of the staff at headquarters. There is no harder-worked body of public servants than the commissioners, who have an amount of administrative and inspecting work to do that it is quite beyond their powers. If the public require, as they have the right to require, proper inspection of all lunatics and asylums, they should insist on having the present staff multiplied by ten. If they are not prepared to find the necessary funds, then like Eliza Hawkins, they have only themselves to blame.

Midwives Act Failure.

The Midwives Act, conceived in ignorance and born in fatuity, can, as has frequently been pointed out, only be of benefit to the public if administered under medical supervision and in consonance with medical opinion. At present chaos reigns throughout the land from the egregious Central Midwives Board to the humblest Betsy Prig who uses her obstetric scissors alternately to cut the umbilical cord and trim her luxuriant nails. In most districts it is a farce, and a farce not untinged at times with tragedy. It is perfectly hopeless to expect the class of women who become midwives to maintain a high standard of work unless they are under direct supervision and not merely "inspected" once or twice a year. An

example of how badly the bad machinery provided by the Act may break down is provided by the county of Hampshire, where last week Colonel Grimston, Chairman of the General Purposes Committee, presented a report to the County Council saying that since the Council had delegated their duties to the urban and rural district councils, the work over a third of the county had simply not been undertaken. The Council, after a long discussion, agreed to form a central committee, on to which they could co-opt ladies to work the Act, and then by way of letting the committee work out its own salvation, the Council accepted an offer from the Hampshire Nursing Association to inspect midwives at a guinea a head! What qualifications have the Hampshire Nursing Association for the work, we wonder, and why should the County Council pay such a price for their assistance?

Lourdes.

ONE result of the religious struggle which is raging in France at the moment is that Lourdes is more than usually full of victims of disease and superstition. The rumour has gone forth that the French Government are likely soon to close Lourdes as a health resort, but whether it be true or not we have no definite information. Certainly from all accounts the Government might well turn their attention to the state of things prevailing in the town. In the hope of cure the halt, maim, and blind in all stages of sickness are being bundled into the town by their relatives, while railways, hotel proprietors, and all the hangers on of the resort are making what they can out of the poor folk. We suspect it is little enough in most cases, as the patients are drawn from the peasant class who have not much in the way of savings to spend, but generally it is their all that goes in the pilgrimage. The accommodation provided by the town is scanty and the people are herded, sick and well, into shells under sanitary conditions described as revolting, and the whole performance seems to be an outrage on decency. In this country we have our troubles, but we are, at any rate, spared having a Lourdes.

The Sunday Fund.

CHARTERS, like wives, are good things to obtain, but, like wives, they are correspondingly difficult to be dispossessed of. Charters are fashionable just now, and all sorts of bodies are applying for them. Even the herbalists want one. But chartered bodies, whether companies or colleges, once created, are apt to operate against the public interest, however worthy and benevolent their original function. The Metropolitan Hospital Sunday Fund, than which no body could have a more noble aim, are applying for a charter, but we cannot help thinking their demand is premature, and we earnestly trust that they may see their way to hold over their application for the present. The subject of charitable hospital maintenance is now in the melting-pot, and till it can be moulded into consistent form it is in the highest degree unwise that any particular or sectional interests, especially vested interests, should be created. Hospital abuse has never reached the pitch that it has attained of late years, and the extravagance of certain hospitals which can rely on having their debts paid is notorious. Till some body can undertake the central control of the London Hospitals, no particular body should seek to acquire particular powers. If the Hospital Sunday, the Saturday, and the King Edward VII. Funds combined their energies—there is no reason in logic for their separate existence—a board might be formed which would command general respect. At present there are too many people pulling different ways, and the public and the medical profession suffer.

Medicine Tasting.

THE "therapeutic nihilist" is regarded by those physicians who believe in treatment as the outcome of a want of knowledge of the actions of drugs and the methods of combining them artistically. There is a great deal to be said for such a view, for certain it is that in the present day when bacteriology and other cognate subjects loom so largely in the medical curriculum, therapeutics and pharmacy have to take a back seat. Consequently the newer order of practitioner is but ill-equipped with the necessary armament to please his patient, even if he be all the better equipped, as one must hope he is, for cure. Some such experience, we take it, must have induced the medical profession at Los Angelos to appoint a lady as a "medicine-taster," a post which a certain Miss Mary Brooks holds with satisfaction to herself and advantage to the patients. So far—we have no information as to how long she has held her delectable appointment—Miss Brooks looks well and happy, and is said to enjoy the best of health. We should imagine that the amount and variety of medicine she must consume would suffice to nip any incipient ailment in the bud, and so it seems to do. Miss Brooks is said also to enjoy a large salary, so that it is unlikely that she could be induced to come over here; but there must be many patients who would gladly employ such an expert, and we commend this new avenue of industry to "superfluous women" on the look out for a "job."

Ventilation in the House of Commons.

HIS MAJESTY'S faithful Commons are constantly quarrelling with the air they breathe during the performance of their "duties," and when it is considered that some 670 of them, more or less according to circumstances, a mass of pressmen, a couple of galleries full of eager constituents, and an indefinite number of distinguished strangers sit for some nine hours continuously in a chamber of limited size, whose windows will not open, the wonder is that any live to grumble. The ventilating machinery of the House was ingeniously designed by Dr. Boswell Reid and Mr. Barry some fifty years ago, and take it all round

it is as good a system as obtains in most public meeting places. Still it is far from being perfect and the just-published report of the last committee appointed to examine the question does not materially help from the practical point of view. The proportion of carbonic acid, the temperature, the relative humidity and the bacteriological purity of the air are found to be all that can reasonably be expected, and the committee feel they must still continue their researches if they are to locate the faults in the arrangements. It is significant to notice that what members most complain of is the languor and lassitude produced by sitting in the chamber, and if we are not presuming to step in where angels fear to tread, we should venture to suggest that what is needed is fresh air. Every day experience informs us that outside air has an indefinable quality of "freshness" which indoor air lacks, and this quality cannot be analysed in beakers or cultivated in test tubes. Opening the windows of the House might make the members "sit up," but it would cure their lassitude and stimulate their loquacity. There are those who might think that the latter event was an equivocal blessing.

Law for Lawyers and Law for Doctors.

At the Lambeth Police Court on Friday last, the fact was once more forcibly illustrated that it is virtually impossible for an unqualified man to practise under false pretences as a solicitor. He cannot with impunity assume a title implying in the remotest way that he is legally qualified, he cannot employ terms or expressions in his business letters capable of being so misinterpreted by a simple reader. The law is clear, the Law Society very much on the alert, and magistrates invariably ready to inflict severe penalties on offenders. On the same day at the County of London Sessions the grotesque comparative weakness of the Medical Acts was once more exposed. A quack was sentenced to fifteen months' hard labour for assaulting a girl who had been for many years an epileptic and whom he had undertaken to cure. The quack had no medical qualification whatever, but had for a long time succeeded by his plausible manner in imposing upon ignorant people and passing himself off as a doctor. The latter offence, unless the pretender is stupid enough to adopt a title specifically named in the Medical Act, does not render him amenable to the law, and whatever offence in this direction he may be guilty of, it is not by any means certain he will be interfered with, since there exists no public prosecutor with the obligation of enforcing the law. The Medical Council has no power to interfere, and there exists no public or professional organisation similar to the Law Society discharging like functions in the control of the profession and safeguarding its own interests as well as those of the public. Hundreds of medical quacks are in practice all over the country; a large proportion of them are really criminals living by the plunder of suffering humanity, and carrying on their nefarious trade with perfect safety so long as they do not incur a charge of manslaughter or commit some offence which brings them within the scope of ordinary criminal statutes. It is difficult to believe that this state of things could be allowed to continue if the people and the Legislature which represents them were once made fully to realise the evils and abuses which the present system allows.

PERSONAL.

Mr. Herbert H. Brown, M.D., has been appointed a Governor of the Ipswich School, in accordance with the requirements of the new scheme, dated May 30th, 1906.

The Royal Dental Hospital of London has received £500 from the executors of the late Mrs. Hannah Finnie, with the stipulation that the amount be invested, and the income therefrom applied to the objects of the hospital.

Mr. H. T. Butlin, D.C.L., F.R.C.S., has been elected vice-chairman of the Committee of Medical members of the London University Senate.

The Moxon Medal of the Royal College of Physicians, which is given every third year, has been awarded to Dr. Jonathan Hutchinson, F.R.S.

Professor von Bergmann has been summoned to Constantinople. One of the Sultan's doctors has been promoted to the rank of General.

Baron Eiselberg, Professor of Surgery at the Vienna University, has recently been operated on for appendicitis. The morning before the operation, Baron Eiselberg himself performed two serious operations on patients, which lasted in all four hours.

It is reported that Dr. Frank Billings, who went from Chicago to New York to attend the late Mr. Marshall Field, the millionaire, is to receive a £5,000 fee. This is said to be the largest fee received by an American physician.

Dr. Seymour Stritch has been appointed a Justice of the Peace for the City of Dublin.

Dr. M. J. Russell has been appointed Superintendent Medical Officer of Health for the South Dublin Union.

Mr. F. H. M. Parker, M.A.Oxon., barrister-at-law, has been appointed Secretary to University College Hospital Medical School.

The Chief Secretary for Ireland has appointed Sir William Thomson, C.B., M.D., to be Inspector of the Schools of Anatomy for the provinces of Leinster, Ulster, and Connaught, in the room of William J. Martin, Esq., M.D., deceased.

At a recent meeting of the Court of Assistants of the Society of Apothecaries of London, held at the Society's hall, Blackfriars, Mr. E. Parker Young, M.R.C.S., L.S.A., was chosen as Master, and Mr. George Wilks, M.B., M.R.C.S., L.S.A., and Mr. F. Gordon Brown, M.R.C.S., L.S.A., surgeon to the City of London police, were elected respectively as Senior and Junior Wardens for the ensuing year.

The court of the same Society unanimously resolved that the freedom of the Society should be conferred upon Alderman T. B. Crosby.

A CLINICAL LECTURE
ON
TUBERCULOSIS AND DISEASES OF THE SKIN.

By JONATHAN HUTCHINSON, LL.D.Oxon., Hon.M.D.Dub., F.R.C.S., F.R.S.,
Consulting Surgeon to the London Hospital, the Hospital for Diseases of the Skin and Royal London Ophthalmic Hospital.

GENTLEMEN,—In continuation of our lectures, I have to-day to deal with tuberculosis in reference to its manifestations on the surface of the body, that is, diseases of the skin which are in some way connected with the presence of the tubercle bacillus. Physicians have been disposed to claim tuberculosis as their own peculiar possession, and some have appeared to regard diseases of the skin with a feeling approaching almost to contempt. I hope to convince you that tuberculous diseases of the skin are well worth studying separately as to their own peculiar characteristics, and also as to their bearing upon other forms of tuberculosis.

There are a number of different affections of the integument, not, I think, all of them the results of inoculation, although one of the questions that one constantly has to investigate in reference to tuberculous manifestations on the surface of the body is, Are these all the result of inoculation? I suppose most of you are aware that the common conceptions regarding tuberculosis are in favour of most forms of tuberculosis being the result of the introduction of the tubercle bacillus into the body. I refuse to accept the view that pulmonary phthisis, for example, usually originates from actual infection, or, in other words, that "the patient took in the bacillus, and then he got pulmonary disease." I think that is to a large extent a mistake, as I shall endeavour to show in relation to various skin diseases. I shall endeavour to impress upon you the fact that the tubercle bacillus is quite capable of remaining latent for a long time, and yet is quite ready to be active when a favourable time comes. That is an important general doctrine as regards all forms of tuberculosis. All varieties of tuberculosis depend more or less remotely on the presence of the tubercle bacillus, but this organism is often not very active, and sometimes has no tendency to produce symptoms at all.

Perhaps the best-known variety of tuberculous affections of the skin is that which goes by the name of lupus vulgaris. It is generally acknowledged that lupus vulgaris is a tuberculous disease of the skin. The tubercle bacillus has been found in the granulomatous lesions which characterise the disease. Here is an example (diagram shown) of the ravages of lupus vulgaris on the surface of the nose. It has for years crept serpiginously from its edges until it has eaten away the alæ and the soft part of the skin of the nose. Lupus vulgaris is not a disease of the bone; it begins in the skin and keeps to the skin. This (diagram shown) represents a patch of lupus vulgaris on the buttock, spreading at its edge. Here is an example (diagram shown) of lupus scrofulosorum. Its circular outline is suggestive of syphilis. In my last lecture I referred to the impossibility of diagnosing between tuberculous lupus and syphilitic lupus merely from the external appearance of the part affected. Tuberculous lupus may have syphilis as a partner in the concern, so to speak, and in like manner syphilitic lupus may have tubercle associated with it. Only the skilled pathologist can determine whether lupus is purely syphilitic or purely tuberculous, or whether it is a result of the union of the spirochæte and the bacillus. Here is another example (diagram shown) illustrating, as in the first case, the destruction of the alæ nasi and spreading over the patient's face. Here is another (diagram shown) beginning with the nose and spreading to the two cheeks equally. These three cases illustrate the great probability of the disease beginning from the nose. The nose is the part which is most subject to lupus, the reason being that the nose is easily chilled. The chilling deranges the nutrition of the part and thus causes lupus. There is very little of this disease in the tropics. The cold of the English climate is remarkably efficient in producing lupus on the face. Here is another example (diagram shown) of lupus on the face and here another (diagram shown) with large patches on the buttocks and hand, and a patch on the back of the calf of the leg. In extremely exceptional cases patches of lupus vulgaris may appear on the scalp, as has happened in these three examples (diagrams shown). Here is an example in a child (diagram shown) of lupus vulgaris which is eating away the soft part of the nose. In this example (diagram shown) the disease affects the lips, in this (diagram shown) it has begun in the nose, in this (diagram shown) it has commenced in the nose and spread to the cheek, in this (diagram shown) the disease has taken away the soft part of the nose and spread to the cheeks; in this (diagram shown) it has begun in the centre of the nose and no one could tell by its appearance whether it was a case of syphilis or not; it looks like syphilis, but the history would decide the point. Here is a case of multiple lupus (diagram shown) occurring in three or four places, but not in the nose at all. Probably some little injury has produced it. Here is another diagram (shown) illustrating a case of my own, in which during a period of twenty-five years the disease slowly spread to the cheek. Here is another example (diagram shown) illustrating destruction of the nose and the spreading of the disease equally and symmetrically on the cheeks and neck, and tending to become crusty. This example (diagram shown) shows the disease to have spread from the nose to the cheeks and down to the neck, and producing little satellites near to it by infection. The tubercle bacillus or its products have destroyed certain parts and then gradually spread into healthy and unaffected tissue at their borders. The treatment consists in exterminating the bacillus by destroying the entire area which is diseased.

(a) Lecture delivered at the London Hospital, June 26th, 1906.

I want to illustrate another fact in reference to this disease of lupus vulgaris, and that is, it may be multiple. There is a stage in which the disease is not only infective by contagion and continuity, that is, gradually spreading from the first part infected, but there is a stage in which the lupus may be scattered all over the surface of the body.

It is an interesting fact, with regard to multiple lupus, that when the lupus is going to spread all over the skin, it does so within a few weeks of the beginning of the attack. I think that in this particular form of lupus there is some element of contagion, not due to the tubercle bacillus alone, but to a partnership between it and some other virus which makes the disease contagious wherever the patient scratches himself. During a period of from three to six months from the beginning of an attack of lupus, the patient may, by scratching himself, produce patches all over his skin. But, after six months has passed he may scratch himself as much as he likes and he does not get multiple patches. It is clear, therefore, that in the very early stages of the implantation of the tubercle bacillus in the patient's skin there is something which makes external contagion possible. Lupus vulgaris is not a disease due to the diffuse presence of the tubercle bacillus in the blood. My reason for making this assertion is the fact that the manifestations of the disease are never bilateral or symmetrical. Anything circulating in the blood is likely to bring out its manifestations in what we call a bilateral or symmetrical form. I have mentioned to you the main facts as regards lupus vulgaris, which is the best acknowledged example of tubercular lupus.

Concerning other forms of lupus there is a certain amount of dispute. There are various other modifications of the disease. You may, for instance, get cases of what are termed acne lupus. I call it *acne* lupus because I think the expression conveys more to anyone hearing it than if I called it *acniform*. By acne lupus I mean that particular variety of lupus in which the patient has real acne on the face. Previously he has had inflammation of the sebaceous follicles of the face, but, being a tubercular subject, this inflammation has assumed a condition of lupus, a condition in which the disease has a tendency to spread at its edge. This tendency to spread is proof that there is something infective, and that something is in connection with the tubercle bacillus.

Another form of lupus is that known as lupus eczematosus, which manifests a tendency to heal and then break out again, and which you cannot cure like pure eczema.

You may also get cases which are known as lupus erythematosus, a disease which begins generally on the face, but is very rarely confined to the face, spreading also on the hands and arms. There is a great dispute as to whether this disease is really lupus. I think it certainly deserves the name of lupus, because it destroys the skin and leaves a scar where it has been. The tubercle bacillus is never found in lupus erythematosus, but, nevertheless, I have not the least doubt that it is really a tubercular disease. That view is strongly supported by clinical evidence, which, I maintain, ought not to be wholly thrust aside by evidence obtained from observation by the microscope. This disease of lupus erythematosus is constantly seen in patients suffering from pulmonary phthisis, and I claim that it is tubercular in character. There are certain cases of lupus erythematosus which it is exceedingly difficult to distinguish from lupus vulgaris, and sometimes you get these two forms of lupus in the same patient. But, as I have already said, I have no hesitation in classing lupus erythematosus along with lupus vulgaris as a tubercular disease.

The next skin disease to which I would draw your attention is that termed lichen scrofulosorum, a form of lichen which occurs in scrofulous patients. None of us have any idea of scrofula except in connection with tuberculosis. It is very often in association with other morbid diseases, but still it is always connected in some way with the tubercle bacillus. The term *lichen scrofulosorum* means lichen occurring in a patient who has the tubercle bacillus or some of its products. This lichen scrofulosorum is a very interesting malady which we are only just beginning to recognise in England. It manifests itself at first as a little brown spot on the skin, with other tiny brown spots near to it. This is a typical example (diagram shown) of lichen scrofulosorum in the final stage of the disease. Lichen scrofulosorum is sometimes called, on the Continent, miliary tuberculosis. The tubercle bacillus has been found in lichen scrofulosorum, and I do not think there can be the slightest doubt that it is purely a tubercular disease. I remember a man who came to me suffering from lichen scrofulosorum. His father had died of pulmonary disease and his brother also came to me with tubercular gland disease. I connect that lichen scrofulosorum in that man with tuberculosis in his father and scrofulous gland in his brother. Lichen scrofulosorum, in the first stage, does get well. I have seen that man quite recently and his skin is perfectly cured. You will, I think, be willing to regard that case as proof that this disease of lichen scrofulosorum, in its initial stage, is perfectly curable.

I now come to a very interesting malady which has received the name of Darier's Dermatosis. In this affection the skin of the trunk and especially the chest and abdomen is covered with small comedonous papules. They are arranged somewhat in groups, but may become confluent and almost universal. The condition lasts for years and may become more and more aggravated the longer it lasts. Its subjects are usually young adults, but it is a rare affection and no large number of typical examples have been placed on record. The distinguished physician whose name it bears discovered certain ovoid bodies in the deeper layer of the corium which he thought were zoospores and of a parasitic nature; but I believe it is now generally acknowledged that the appearances are the result of degenerative changes and not of a parasitic nature.

We have recently had under observation at the Polyclinic two excellent examples of this skin disease, both of them kindly brought to us by Dr. Hartigan from the Blackfriars Hospital. The investigations of these two cases has convinced me that the malady is only an exaggerated form of Lichen scrofulosorum. I have arrived at this conclusion by observing the differing characters of the eruption in different parts of the surface, and by comparing its features with those figured by

authors under the latter name. I show you drawings and photographs of Dr. Hartigan's patients, and I show also drawings from various atlases illustrating the form of lichen to which I refer. These are certainly all gradations in the changes delineated, and I do not think that anyone examining them can doubt that they should all receive the same name.

Darier figured in one of his cases an acutely inflammatory condition of the skin of the pubes and lower part of abdomen, resembling an acute, exudative eczema. Now one of our recent cases had this same complication, though not the abdomen but the forehead and scalp were its sites. The clinical history of the cases usually fits in with the diagnosis of scrofula. It may be added, in further corroboration of the diagnosis, that Dr. Hartigan found the ovoid bodies described by Darier in great abundance in one of his patients, and the two were exactly alike.

I feel justified, then, until some evidence to the contrary is forthcoming, in asking you to regard Darier's Dermatosis as a very chronic and aggraved form of lichen scrofulosorum. Thus we effect a simplification, and restrict our nomenclature.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this Journal. The lecture for next week's issue will be by Herbert Stanley French, M.D.Oxon., M.R.C.P., Medical Registrar, Guy's Hospital, on "Some Points with Regard to Empyemata," delivered at Guy's Hospital, June 6th, 1906.*

ORIGINAL PAPERS.

HÆMATEMESIS.

BY GEORGE CHAPPEL, M.D. CANTAB.,

Physician to Out-Patients, Tottenham Hospital.

IN diagnosing and treating a case of hæmatemesis our first and often great difficulty is to make out definitely the source of the bleeding. In addition to gastric ulcer (whether simple or malignant) there are many causes which may give rise to the presence of blood in the stomach, and to its being subsequently vomited. The commonest and most important of these is hæmoptysis. The history will often give us a clue, but is not infallible, as patients who have lost a great deal of blood are often too nervous to give a history which can be altogether relied upon. The point to be noted especially is the condition of the blood. In hæmoptysis the blood is of a bright scarlet colour, alkaline in reaction, frothy from admixture of air, and comes up with a cough; usually there has been a cough before the onset of the hæmoptysis. In hæmatemesis the blood is usually more or less altered in colour, being darker from the action of the gastric juice; on standing it tends to become brighter from taking up oxygen from the air. It will probably be acid in reaction, and may be mixed with particles of food. With hæmatemesis there is often associated a slight cough due to irritation set up by the passage of the vomited blood over the orifice of the larynx. In addition, however, in true hæmoptysis there may be some hæmatemesis from blood from the lungs having been swallowed. Roughly, we may say then that if the blood is preceded by cough the hæmorrhage is from the lungs, if the cough is coincident with the blood the probability is that it comes from the stomach.

In epistaxis, or in fracture of the base of the skull, if the patient is unconscious, blood may run down the œsophagus and be swallowed so that it enters the stomach and when rejected is hæmatemesis. Oozing from the tonsils, gums, carious teeth, or pharynx in various diseases may again simulate slight hæmatemesis. Anæmic girls not infrequently speak of having brought up blood which is small in amount and occurs in the early morning. In these cases blood probably comes from the naso-pharynx. Feigned or hysterical hæmatemesis is due to continual gum-sucking, self-inflicted wounds or extraneous blood introduced into the mouth.

In the œsophagus we occasionally get varicose veins which ulcerate, and the blood runs down into the stomach; this when vomited is indistinguishable from true hæmatemesis. Carcinoma of the œsophagus and an aortic aneurysm leaking through the œsophageal wall will also cause the same condition.

In *True Hæmatemesis* the blood is usually forcibly vomited and may be expelled through the nose as well as the mouth. Before its onset the patient may feel distended, uncomfortable, faint, and become blanched. The blood is generally more or less altered in colour, being darker from the action of the gastric juice; on standing it tends to pick up oxygen from the air and become brighter; it will probably be acid in reaction, and may be mixed with food.

When in copious hæmatemesis the blood is of an arterial character, rapid hæmorrhage from an artery eroded by a gastric ulcer has probably taken place. When, however, it is black, clotted and copious, the hæmorrhage probably depends on cirrhosis of the liver. Small coffee ground vomit is especially associated with carcinoma of the stomach, for the blood is slowly poured out, and is extensively acted upon by the gastric juice.

Frequency.—Repeated large hæmorrhages may be due to ulcerated varicose veins at the lower end of the œsophagus in cirrhosis, or to minute erosions of the gastric mucous membrane, or to gastric ulcer, and may so exhaust the patient as to be fatal. A single hæmatemesis is rarely fatal unless it is due to the rupture of a large aneurysm into the stomach or œsophagus. Small coffee ground vomiting, especially when repeated, is strongly indicative of carcinoma of the stomach; in these cases the vomiting is not due to the presence of blood in the stomach, but is reflex and depends on the irritation of the growth; any blood that is in the stomach being brought up with the gastric contents. In large hæmatemesis the vomiting is the result of the mechanical stimulation of the gastric muscular walls by the distension of the organ with blood.

Causes and Source.—We have seen that the blood may come from the œsophagus as the result of eroded varicose veins; in addition duodenal ulcers may give rise to regurgitation of blood into the stomach and cause hæmatemesis, and an abdominal aneurysm rupturing into the duodenum has been known to cause a fatal attack of hæmatemesis.

In the stomach gastric ulcer is the most common cause; it occurs most frequently in young anæmic women, and is commonly situated near the pylorus. It also occurs in men, but as a rule at a rather later time in life, and may be situated in any part of the stomach. Repeated and large hæmorrhages may occur from very minute abrasions of the gastric mucous membrane. Small ulcers may supervene in chronic congestion of the stomach as the result of localised hæmorrhages into the mucous coat; they may open up a vessel and give rise to profuse bleeding. Dr. Fenwick says that in the passive congestion due to cirrhosis these ulcers usually open up a vein, whereas in that due to cardiac disease an artery is usually eroded.

Among other rare causes of hæmatemesis are aneurysms of the gastric, hepatic, or splenic arteries opening into the stomach. Carcinoma of the stomach may arise at any part of the organ; the hæmorrhage as a rule is slight in amount, and, as we have noted, is usually retained in the stomach, with the result that we get the coffee ground vomit due to the prolonged action of the gastric juice on the blood.

Minute lesions of the gastric mucous membrane occur in acute gastritis as the result of large quantities of spirit, acids, or other poisons. The backward pressure consequent on heart disease, cirrhosis of the liver and thrombosis of the portal vein is apt to set up degenerative changes in the mucous membrane of the stomach and consequently we get a general oozing of blood; this oozing is probably more dependent on the degenerated condition of the mucous membrane than it is on the purely mechanical engorgement.

Further, we get blood extravasated into the stomach in toxic conditions; chief amongst these are septicæmia, yellow fever, acute jaundice, acute yellow atrophy of the liver and malignant forms of the specific fevers. It may occur in typhoid, but is very rare indeed—in fact, almost as rare as the occurrence of typhoid ulcers is in the stomach. In certain blood conditions, such as leukæmia, pernicious anæmia, purpura hæmorrhagica, and hæmophilia, we find hæmatemesis as a symptom.

The question of vicarious menstruation being a cause of hæmatemesis has been long debated. The late Dr. Matthews Duncan said he had been on the look out for it all his life, but had never seen it. About two years ago there was a young woman in this hospital who gave a history of hæmatemesis at each period; she was carefully watched, and when the period came on it was proved that the blood from the mouth was self-induced. I am inclined to believe that most, if not all, of these cases come under this category.

Diagnosis.—If the patient is a young anæmic woman, and the hæmorrhage is large in quantity, the chances are largely in favour of a gastric ulcer; in these cases there is usually a history of pain coming on directly after food, and relieved by vomiting; also deep pressure will probably elicit a point of maximum tenderness. With small erosions of the mucous membrane, however, tenderness may be absent in spite of the fact that the hæmatemesis may be severe and frequently repeated. Examination of the vomit in the absence of hæmatemesis will show an excess of hydrochloric acid. Melæna invariably follows the hæmatemesis.

Gastric ulcer in men is met with at a later period in life; it is associated with more severe pain, and gives rise to anæmia. It is often difficult to distinguish from carcinoma and cirrhosis, but the quantity and quality of the blood will help in the former case, and the absence of enlargement of the liver in the latter.

Sudden hæmatemesis in a middle-aged person without any previous history of illness will lead one to think of cirrhosis, and the diagnosis will be greatly helped if there is an alcoholic history obtained or if the liver and spleen are found to be enlarged and tender. Hæmatemesis in cirrhosis may be preceded by chronic dyspepsia, but the symptoms are not so severe as in ulcer or carcinoma, and tenderness on palpation over the stomach is more general and less acute than in ulcer.

In carcinoma the quantity and colour of the blood is the distinguishing feature, also the fact that there is usually very little melæna to be noticed. In the vomit there is generally an absence of free hydrochloric acid. To this must be added the presence of a tumour in the stomach, and the age of the patient, which is usually, but not invariably, greater than would be the case in a patient with a simple ulcer.

In duodenal ulcer the pain and dyspepsia should supervene about two hours after food, when the process of digestion in the stomach has gone on and the pylorus allows the contents of the stomach to pass into the duodenum; moreover, the tenderness is more to the right of the median line. Melæna often precedes the hæmatemesis.

Hæmatemesis with fever suggests some severe infection like septicæmia, whilst hæmorrhage in other parts of the body points significantly to a blood condition like purpura.

Prognosis.—Hæmatemesis is rarely immediately fatal. If a large artery like the splenic has been eroded by an ulcer, or a large œsophageal varix has ulcerated, or an abdominal aneurysm has ruptured into the stomach, the immediate outlook is very grave, but in cases of ordinary hæmatemesis recovery for the time being at any rate is the rule. When large hæmorrhages occur at frequent intervals death may result from exhaustion, and in such cases the only treatment is to open the stomach and try to secure the bleeding point.

With regard to the more remote prognosis, that is dependent on the pathological condition which is causing the hæmatemesis; the small coffee ground vomit of malignant disease is thus much more grave than the large hæmorrhage of gastric ulcer.

Treatment should consist of rest, and by rest I mean rest of the body, rest of the stomach, and rest of the mind. The patient must be kept absolutely quiet in bed, with the head low, so as to prevent syncope. Mental anxiety must be relieved. Just as in hæmoptysis, patients get very nervous and excited when they are losing a great deal of blood and this nervous excitement is very dele terious. To combat this the best treatment is a hypodermic injection of morphia. The stomach must be kept quiet, and this end is attained by allowing nothing to be given by the mouth; all nourishment must be given by the rectum for a period of time, which varies according to the pathological condition which has caused the hæmorrhage. Thus it may be combated by small pieces of ice being given to such, but I believe the better plan is by giving water by the bowel.

Various drugs have been given as styptics, such as acetate of lead, gallic acid, and dilute sulphuric acid, oil of turpentine ℥xx. every four hours and opium in different forms. The treatment I have found answer best has been Liq. morph. ℥v. combinedwith acid hydrocyanic ℥ii in a teaspoonful of water every two hours while there is vomiting or pain. Adrenalin chloride has been suggested as a local styptic, but I have not had much experience of it. Some authorities consider that calcium chloride in half drachm doses is useful; it is given with a view to increasing the coagulability of the blood.

Feeding must be by the rectum only. The plan I have found answer best is to give large injections of 15-20 ounces of peptonised milk twice a day. A long rectal tube is passed and the peptonised milk allowed to run slowly into the sigmoid flexure the patient lying on her left side. A convenient way is to have an ordinary douche can hung up on the wall, and the stopcock so arranged that the milk runs very slowly. The time occupied by the proceeding is from 20 to 30 minutes. By this means the whole of the milk is retained and none of it returned, as would be the case if it were given rapidly. Needless to say, the rectum must be washed out with an ordinary soap and water enema each day.

One of the reasons why gastric ulcers relapse is, I believe, because food is given by the mouth too soon. In an ordinary case of hæmatemesis from gastric ulcer, feeding should be entirely by the rectum for at least two weeks; then peptonised milk or mutton broth can be commenced in teaspoonful doses and gradually increased if no trouble is caused.

In cirrhosis liquid food may be given much earlier—as soon as three days after the hæmatemesis, provided there is no recurrence. In the small hæmorrhages of malignant disease, food should be given still earlier.

ABSTRACT OF LECTURE ON THE DIAGNOSTIC AND PROGNOSTIC VALUE OF THE TEMPERATURE IN APPENDICITIS,

By L. CHEINISSE, M.D.,

Ex-Interne of the Montpellier Hospitals.

THE teaching of yore with regard to appendicitis was to operate as soon as a diagnosis was made, and although this dogma is still very prevalent in America, there is a tendency in Europe to treat each case on its merits.

The operative method of dealing with this affection is still, of course, the only curative treatment, but the point to decide is the precise moment at which this should be done, hasty operation being by no means exempt from drawbacks. The points that should guide us in advising operation are: The existence of leucocytosis, although this cannot always be considered *per se* pathognomonic, but only suggestive, of abscess formation; another symptom on which stress is laid is the temperature chart. Many authorities assert that appendicitis may occur without causing any noticeable rise of temperature, but is this really the case?

Mr. Rotter, of St. Hedwig's Hospital, at Berlin, from close observation of 100 cases of appendicitis, observed a temperature in eighty-one, nineteen only being apyretic. Of these latter, five were admitted after the tenth day of illness, and may, therefore, have gone through their pyretic period, while the three remaining ones had generalised suppurative peritonitis, so that Mr. Rotter reduces the proportion of apyretic cases of appendicitis to 11 per cent.

Mr. Herzog, from observation of 189 cases, found 139 with fever and 50 without—that is to say, 74 per cent. belonging to the first class and 26 per cent. to the second. The percentage of apyretic appendicitis in these observations is certainly higher than Mr. Rotter's, but it is due to the fact that patients entering hospital sometimes long after the onset of the disease were not eliminated.

Mr. Rostovtzer, out of 152 cases, found a proportion of 9·5 per cent. apyretic.

It is evident from these researches that fever is almost the rule; at all events, that is the case at the onset of the disease. Hyperthermia, too, is a transient symptom, for out of sixty cases treated and cured in the medical wards, Mr. Rostovtzer noted in thirteen cases (45 per cent.) a temperature lasting one day, eleven times (31 per cent.) two days, and in ten cases (15·5 per cent.) three days, while in eleven patients (8·5 per cent.) it remained up for a week, these results thus resembling those obtained by Mr. Herzog. As regards the height of the temperature, most authorities are agreed that it is never excessive.

Mr. Kümmell's statistics show 185 cases in which the temperature never exceeded 100·2° F., 124 in which it oscillated between 100·2° F. and 103° F., and only 61 in which it was higher than 103° F. Mr. Herzog, from observations on 139 cases in the Bethanien Central-Diakonissenhaus, found:—

Temp. 100·2	— 102·2	in 69 cases	= 49·6 per cent.
,, 102·3	— 103	in 40 cases	= 28·8 per cent.
,, 103·2	— 104	in 14 cases	= 10·1 per cent.
,, 104	— 105·8	in 16 cases	= 11·5 per cent.

From these statistics we may draw three important conclusions with regard to temperature—that it is rarely absent in appendicitis, but is of short duration and not of great severity, frequently never rising beyond 102·2-103. What diagnostic or prognostic significance, then, is conveyed by the presence or absence of temperature? Are we right in concluding that, if apyretic, the case is benign? Mr. Rotter has shown that a sudden severe onset does not preclude a prompt recovery, nor does initial apyrexia always indicate a favourable issue.

Although the mere presence of fever is not sufficient *per se* to give valuable information with regard to the evolution of the inflammation, much light is thrown on the case by considering the intensity, the duration and the general course of the temperature.

A certain number of typical temperature curves may be said to exist. In some the temperature rises suddenly, with or without rigor, is maintained for three days at from 100·5 to 103, and is accompanied by a rapid, strong, regular pulse, then with the improvement of the general symptoms and the disappearance of the pain, the temperature drops. The temperature is generally normal five or six days from the onset, the inflammation being strictly limited and of moderate intensity.

In a second group of cases the temperature

keeps up for a long time, rarely exceeding 102°, and the general condition is good, the abdomen is supple and painless, except in the region of the ileo-cæcal valve. Here, again, the peritonitis is localised, and Mr. Rotter recommends in these cases to wait till the ninth or tenth day, and if then the temperature is still above normal, or, if normal, the local signs do not show any amelioration, intervention is indicated, although the general condition may seem satisfactory. If, however, after the third day of the illness the temperature remains high, or even continues to rise, or, after having dropped a little, begins to rise once more to 102·5 or higher, in these cases intervention is called for, not later than the fourth or fifth day, as these elevations of temperature indicate an extension of suppuration, with the risk of general peritonitis and perforation of the appendix. In such cases other signs are present, such as acceleration of the pulse, vomiting, &c.

The same remarks apply to those attacks of appendicitis which to all appearances are benign are subject to recrudescences and to a remittent type of temperature; and it should be our rule that whenever the temperature, having fallen to normal, begins after a short period of apyrexia to rise again, this indicates the presence of pus, and immediate intervention is consequently required.

As to the prognosis in regard to life, the duration of the fever is of less importance than its intensity. Judging from the researches of Mr. Herzog on the subject, out of thirty cases that ended fatally, in fifteen of them death supervened on the third day, the mortality of cases with a temperature under 102·5 treated in the medical wards was 11·5 per cent., whilst those with a temperature of 104 show a death rate of 36·3 per cent.

Useful as hyperthermia is in determining the severity of a localised peritonitis, it is an almost useless factor in considering the prognosis in general peritonitis, for in bad cases of acute septic peritonitis or general peritonitis which is suppurative from the onset, the temperature, after a preliminary rise within the first twenty-four or thirty-six hours, drops suddenly after the second day, often becoming subnormal. The same drop in temperature is seen in cases of general peritonitis following the rupture of an abscess cavity; therefore, in a progressive peritonitis, in which the lesion has a tendency to localisation, the temperature remains high; consequently hyperthermia is of favourable import.

In this group of cases the pulse-rate and the patient's general condition afford far more trustworthy evidence than the temperature; still, it cannot be ignored, for a fall of temperature coinciding with acceleration of the pulse is of very bad augury and denotes the onset of general peritonitis.

One must regard with suspicion all cases in which the rapidity of the pulse is out of proportion to the temperature, an almost certain sign of suppuration. Mr. Jalaguier points out that suppuration in some cases is shown by a progressive rise of temperature from the onset to 104, and others in which, although the local condition remains unaltered, the temperature drops, but the pulse remains rapid.

There remain two points in the temperature to which attention must be directed. These are interesting as much from the point of view of diagnosis as from that of prognosis and the question of intervention. The first is the difference that exists between the rectal and axillary temperature. Usually the difference in pyrexia is from 0·2 to 0·5 C., but Mr. Madelung has pointed out that in purulent peritonitis the difference is even more marked, and may be as much as 1·5. This is confirmed by Mr. Lennander.

The second point of interest is this, and it has been noted by Mr. Rostovtzer that the maximum temperature does not occur between 4 and 6 p.m., as in most pyrexia, but between 9 and 10 p.m.; this statement is based on the result of 686 afternoon observations of 52 patients, 315 times. In 43·5 per cent. of the cases the maximum temperature occurred between 4 and 6 p.m.; in the majority of cases, which formed 44·8 per cent. of the total number, the highest temperature was charted at 9 and 10 p.m.

Mr. Rostovtzer, grouping the cases according to their severity, found that the temperature had a tendency to attain its maximum in the severe cases later in the evening than in cases of less severity. In the mildest attacks (164 afternoon observations on 22 patients), where recovery took place without surgical intervention, 36 per cent. of them showed a maximum temperature between 9 and 10 p.m.; whilst in a second group, in which an operation was performed, 45·6 per cent. of the cases after intervention developed the highest temperature between 9 and 10, whilst before intervention the maximum occurred at this time in 60 per cent. of nine cases of severe appendicitis, with a fatal termination to 56 (65·1 per cent.), gave a maximum temperature between 9 and 10 at night, and 30 (34·9 per cent.) between 4 and 6. In other words, in the very severe cases of appendicitis the maximum temperature occurs between 9 and 10 at night twice as frequently as in the slighter forms. This being the case, it is important to take the temperature frequently in the afternoon, and to be ready to act if the temperature reaches its maximum at a late hour of the evening—*e.g.*, between 9 and 10 p.m.

CLINICAL RECORDS.

A CASE OF SYRINGOMYELIA.

By T. R. BRADSHAW, B.A., M.D., F.R.C.P.,

Physician to the Royal Infirmary, and Lecturer and Examiner in Clinical Medicine in the University of Liverpool.

This case is an instance of one of the rarer forms of disease of the central nervous system, but a disease which presents symptoms so characteristic that its recognition presents little difficulty to anyone who is aware of the possibility of its existence. It is worthy of notice that most of the rarer diseases present striking characteristic symptoms, which make their recognition easy, at least in well-marked cases. Thus, in Addison's disease there is the obvious pigmentation, in myxœdema the no less obvious swelling of the body, in acromegaly the overgrowth of the bones, in myelopathic albumosuria the unique character of the urine. No doubt it is the association with these noticeable syndromes that has led to each of these diseases being recognised as a distinct and definite pathological state; and we cannot doubt that there are still not a few morbid [states which escape distinctive

recognition because their symptoms closely resemble those of diseases of common occurrence.

The present case clearly presents the characters of the condition known as syringomyelia, though it is exceptional in departing in some of its features from the commonly accepted type of the disease. Here I think it will be best for me to put forward briefly what is known of the morbid anatomy and pathology of this interesting affection. Cavities of various kinds are met with in the spinal cord as in other parts of the central nervous system. Thus a hæmorrhage, instead of becoming absorbed, may remain as a cyst or hæmatoma, and there may be a dilatation of the central canal of the cord as there may be of the ventricles of the brain, constituting a hydromyelia. The nature of the cavities in syringomyelia has not been thoroughly determined, but the trend of opinion is towards the view that they originate in a gliomatosis, or overgrowth of the neuroglia, which undergoes liquefaction in its central parts, so as to form one or more cavities with smooth walls, and containing a clear or turbid fluid. The cavities are formed in the grey matter in the neighbourhood of the central canal, with which they sometimes communicate, and they spread in various directions in the deeper parts of the cord, which may, in extreme cases, be converted throughout part of its length into an elongated cyst, so much of the nervous tissue as survives being crushed together in its walls. The change generally begins and is most advanced in the cervical region, but in exceptional cases, of which the present appears to be one, the brunt of the disease falls upon the lumbar enlargement.

The essential facts in the case of the patient I now show you are as follow :—

J. B., a labourer, æt. 54, began to suffer fifteen years ago from trouble about the feet which made walking difficult. Attacks of this kind recurred from time to time until they became continuous. The toes became strongly and permanently flexed and otherwise deformed, and six years ago some of the smaller ones on the right foot were amputated by a surgeon, but without any material benefit to the patient.

At the present time his condition is as follows : The general appearance is that of health, and the thoracic and abdominal organs are sound. The limbs, however, present several important departures from the normal.

Motor.—There is complete paralysis with wasting of the anterior tibial muscles, resulting foot-drop and flexion of the toes. A characteristic difficulty in walking results, the feet being raised too high and kept wide apart to enable the toes to clear the ground. The defect in walking is increased by the existence of extreme flexion at the first interphalangeal joint of the smaller toes, apparently due to shortening of the flexors. In the hands there is no obvious paralysis, but there is a similar deformity of the fingers, due apparently to shortening of the flexor profundus digitorum.

Reflex.—There is complete absence of the patellar and plantar reflexes.

Trophic.—As already stated, certain muscles are wasted. There is also marked change in the nutrition of the skin. When first admitted to hospital there were numerous small ulcers, apparently painless, on the lower part of the legs and the feet, and a purpuric eruption on the feet. These have healed to a considerable extent, but can still be recognised. A corn on one of the toes has ulcerated since he has been in bed in hospital.

Sensory.—Here the most characteristic changes are observed. In the region corresponding to the fourth and fifth lumbar and first sacral segments, that is, approximately, the whole of the legs below the knees, the sense of pain is almost gone. The prick of a pin causes little or no pain ; but the slightest touch is felt and correctly located. Throughout the same region the ability to distinguish heat and cold is quite lost ; a test-tube containing iced water touching the skin cannot be distinguished from one containing warm water. In the hands the only alteration of sensibility is some confusion of hot and cold sensations in the right middle and ring fingers.

The sphincters are normal.

The paralytic and other symptoms are somewhat more marked on the left than on the right side.

It will be noticed that the clinical picture, while pointing to some profound change in the nervous system, does not conform to that of any of the commoner affections. It bears some resemblance to multiple neuritis and to locomotor ataxy, but differs from both in certain essential points. In neuritis the progress would be more rapid and the disease would not last so long, there would be tenderness of the nerve trunks and muscles, and above all there would be no dissociated anæsthesia. Anæsthesia there might be, but all forms of sensibility would be pretty equally affected.

From locomotor ataxy the case is distinguished sharply by the presence of paralysis and wasting of muscles, a distinction which is confirmed by the absence of inco-ordination, of pain, of visceral symptoms, and of tachycardia. In this connection I should like to draw attention to what I consider the extreme importance of permanent acceleration of the pulse in the diagnosis of early cases of locomotor ataxy. I have at present five cases of locomotor ataxy, in various stages of development in my wards, and in all of them the pulse is persistently accelerated, being generally about 100 per minute, sometimes considerably higher. In the present case the pulse is usually between 60 and 70.

We will now consider the grounds on which is based the opinion that the case is one of syringomyelia.

Authorities are agreed that the characteristic indication of syringomyelia is the presence of a complexus of symptoms, all of which are present, in this case—symptoms which may be found independently in other morbid conditions, but which experience proves are never found in combination in any other disease. These symptoms are three—namely, loss of certain sensations, while others are retained ; the presence of paralysis, with wasting of muscles ; and trophic changes in the skin and other structures. Of these the most characteristic symptom, taken by itself, is the partial loss of sensibility—the "dissociated anæsthesia" of Charcot. Normally, we are conscious of three kinds of sensation in the skin—sensation of pain, of touch, and of temperature. In most conditions of impaired sensation all these

kinds of sensibility are lost in about the same proportion, but in syringomyelia it is otherwise. In this disease the sense of touch is generally normal in every respect, but the sense of pain and the power of distinguishing hot and cold objects in contact with the skin are more or less completely lost. This peculiar dissociation of sensation is not easy to explain; but in view of the pathological anatomy of syringomyelia, its occurrence lends colour to the hypothesis that the paths of the different kinds of sensation in the cord are not the same, and that sensations of pain and of temperature pass through the grey matter. The distribution of the anæsthesia corresponds to the segments of the spinal cord affected, and does not, as in the case of peripheral neuritis, correspond to the distribution of the sensory nerves. In consequence of the loss of sensibility serious injuries may be unnoticed by the patient, and to this some of the trophic changes are doubtless due.

The distribution and nature of the muscular paralysis are such as we might infer from what we know of the morbid anatomy. If the lesion is in the cervical enlargement, there will be paralysis, with wasting of the muscles of the upper extremity, corresponding to the spinal segments involved, and the muscles of the trunk and even of the lower extremity may suffer in succession. More common is it to find the lower limbs indirectly involved from pressure on the pyramidal tracts, there being no wasting, but spasticity of the muscles with exaggerated reflexes. A case of this kind might readily be mistaken for progressive muscular atrophy. When, however, as in the present case, the lesion is chiefly located in the lumbar enlargement, there is simply more or less paralysis of the muscles, with atrophy, loss of reflexes, and degradation or abolition of electrical response.

The nutritional disturbances in the limbs are of various kinds and may affect any of their structures. In the present case the smaller toes are much deformed, apparently from shortening of the flexor tendons and disorganisation of some of the joints; there is an indolent ulcer on the sole of the foot, reminding us of perforating ulcer; there are multiple ulcers on the leg, and a purpuric eruption on the feet. The stiffness and flexion of the fingers is, I feel sure, one of the manifestations of the spinal cord affection, though I do not find that such a condition has been previously described in this disease. A painless disorganisation of the larger joints, like that described by Charcot in locomotor ataxy, has been met with in some cases, and painless fractures have been described. The present case is exceptional in the advanced age of the patient, as well as in the locality affected. Though cases are occasionally seen late in life, the great majority of those recorded have been in patients under 40.

The progress of the disease is commonly, as in the present case, exceedingly slow. It may spread upwards to the medulla oblongata and so prove fatal, but as a rule it does not directly tend to shorten life.

The treatment must be symptomatic and palliative, since we have no means of influencing the processes at work in the spinal cord. It is thus on the same lines as the treatment of the commoner degenerations of the spinal cord. The absence of pain calls for vigilance on the part of the practitioner, since the patient, feeling no discomfort, may take no notice of more or less serious injuries, with the result that troublesome ulceration may arise and be the source of various forms of septic infection.

THE OUT-PATIENTS' ROOM.

KING'S COLLEGE HOSPITAL.

Malignant Epulis.

By Peyton Beale, F.R.C.S.

A man, æt. nearly 60, presented himself complaining of a large ulcerated mass on the right side of his hard palate; the growth looked as if it involved a considerable portion of the upper jaw as well. The history was of about three months' duration, but it was impossible to find out from the patient exactly where it started—*i.e.*, whether from the gum, from the tooth-socket, hard palate, or the upper jaw itself. From its appearance it was supposed to be an epithelioma starting in the palate. A small piece was removed, and on microscopical examination was found to be a spindle-celled sarcoma. The growth seemed to be adherent to the palate, and any attempt at stripping or peeling it off appeared hopeless. There was no evidence of any growth within the antrum. Mr. Beale said that the commonest form of malignant epulis was myeloid sarcoma, perhaps the next most common was squamous epithelioma, and this tended to involve the upper jaw and antrum extensively as a rule; he believed a spindle-celled sarcoma to be the least common form of malignant epulis. The history of these cases was generally that of the appearance of a small tumour at the edge of a tooth-socket, coming soon after the removal of a tooth, but there was nearly always a history of considerable damage to the alveolar process during extraction.

The case, Mr. Beale said, would be admitted to the hospital and operated upon. The operation he proposed to do consisted in making an incision round the growth on the hard palate, when the tumour, together with the mucous membrane, would in all probability be stripped off with ease; it would then be seen from which part of the alveolus the growth originally sprang, and this would be removed with chisel or cutting forceps. Care would then be taken to make sure that no part of the growth was extending up into the antrum.

OPERATING THEATRES.

ST. THOMAS'S HOSPITAL.

Abdominal Operation for Traumatism.—Mr. Edred Corner operated on a little girl, æt. 5, who had fallen from a window on to some area railings, impaling her abdomen thereon. She had been brought to the hospital with most of her intestines prolapsed and exposed as she was carried through the street. On admission she had much shock, and was taken to the theatre as soon as possible. At least three-quarters of an hour had elapsed in bringing her up to the hospital, &c., before the operation and all the while her intestines were prolapsed. The intestines and skin were cleaned up with as much saline as was possible. Four rents in the bowel and two in the mesentery were sewn up with silk. After further washing with saline, the intestines were returned to the abdomen. Whilst repairing the abdominal wall it was found that the left rectus has been completely torn across. The peritoneum was sewn, then the rectus, then both recti sheaths, which were torn extensively and transversely. As a precautionary measure the child was given three

doses of anti-colon serum. The abdomen was no washed out. Mr. Corner said that the interesting points in this case were: (1) The severity of the injury in one so young; (2) when a bowel is ruptured the rupturing force seems to paralyse it, so that little or no fæces are extravasated; (3) the necessity to hunt up and see to all of the many injuries and overlook none; (4) in one place the bowel was separated for an inch and a half from its mesentery, but it did not seem to have suffered much in spite of being so separated from its blood supply; (5) the giving of the anti-colon serum in anticipation of an infection with the colon bacillus would, he thought, contribute to a successful result; (6) it was, he considered, better to make no attempt to wash these cases with soap and water or any antiseptic, but to depend on the mechanica action of flushing with normal saline; chemicals injure the peritoneum, impoverishing its resisting power to the onslaught of organisms which must be present after such an injury.

It is satisfactory to state that after two or three days' illness the child became quite convalescent. Mr. Corner thought that the two or three days' illness indicated some infection by the colon bacillus which, as he had predicted in No. 5 of his points of interest, had been successfully combated by the giving of the anti-colon serum.

ROYAL FREE HOSPITAL.

CHRONIC ABSCESS OF THE BREAST.—MR. J. P. LEGG operated on a woman æt. 43. The patient stated that for five weeks she had noticed an aching pain in her left breast. Previous to this time she had been quite well. The nipple was a little sore at the time, but it soon got better. During the next ten days the pain got worse, and a lump about the size of a marble was discovered. It had steadily been increasing in size, and getting harder. Two swellings had also been noticed in the left axilla, and three weeks after the onset of the symptoms the skin over the breast became red and œdematous. There was no history of injury. the patient was a married woman, the youngest child being thirteen years of age. On examination the patient was exceedingly stout. The left breast was about half as big again as the right. She stated, however, that it had always been slightly larger than the right, but recently much more so. The skin over the whole breast was red, infiltrated and œdematous; the subcutaneous veins were slightly larger on the left side. On palpation a tumour as large as an orange was felt just above the nipple. It was very hard and had rather an irregular surface, the edge being fairly well defined. The skin dimpled on trying to slide it over the surface of the tumour. There was no discharge from the nipple, which was healthy. There was very little local pain.

In the left axilla some small hard glands could be readily detected. The right breast was normal. An exploratory incision was made into the mass and a large quantity of pus escaped. The abscess was found to occupy the centre of a dense mass of hard tissue, and therefore the whole swelling was removed by dissection for further examination, care being taken to cut wide of the walls of the abscess and to include a considerable amount of the adjacent breast tissue and fat. A drainage tube was placed in the upper part of the incision which was closed by interrupted sutures. Mr. Legg said that this patient illustrated exceedingly well the difficulty in diagnosing breast tumours. Here was a woman with a hard, painless tumour presenting many of the local signs of carcinoma. At the same time there were present some of the signs of inflammation, viz., the redness and persistent œdema of the skin and a tumour. The diagnosis lay between an inflamed, rapidly-growing carcinoma and an abscess. There was, he thought, no very obvious cause for an abscess, and the local signs were not suggestive of tuberculosis of the breast. Delay in the case of any tumour of the breast, he pointed out, was always contra-indicated. If the tumour was a carcinoma the sooner the patient was rid of it the better would be her chances of recovery. If the tumour turned out to be inflammatory, the sooner would she recover. Therefore, in the present case, it was decided to find out the nature of the swelling by making an incision and cutting out the mass. Until the mass was actually removed, its inflammatory nature was not clear. The walls of the abscess were so dense and hard, the possibility of a carcinomatous growth being present could not be excluded till a section was made. After removal the mass appeared to be inflammatory, it had a glistening white appearance, and this was confirmed subsequently by the microscope. All tumours of the breast, whatever the age of the patient, should be removed, he considered, and a careful microscopic examination made. For experience shows that cancer is not very uncommon in patients under thirty years of age. On examining the mass removed, it was found to consist of a cavity 1½ inches in diameter having a lining membrane of granulation tissue, the walls of the cavity being composed of dense fibrous tissue fully one inch thick. Microscopical sections did not show any evidence of malignancy. The adjacent breast tissue showed extensive chronic inflammatory changes. The patient made a good recovery, and left the hospital at the end of ten days.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Aug. 19th, 1906.

CHRONIC RETENTION OF URINE.

CHRONIC retention of urine arises from different causes: (*a*) bladder (paralysis of medullary origin, vesical sclerosis); (*b*) urethra (stricture, gonorrhœal or traumatic); (*c*) periurethral (compression in woman from pregnancy, fibroma, pelvian kysts); (*d*) prostate (compression by the lateral lobes of the gland).

In all these cases, says Prof. Legen, the bladder struggles successfully for a time, but finally the vesical muscle yields and retention is the result, and of which there are three types—incomplete retention with distension, incomplete retention without distension, complete retention.

The first-named is the gravest and the most difficult to treat. A large quantity—frequently a quart—remains in the bladder, although the patients urinate night and day. The urine is limpid and aseptic. Another consequence of this incomplete retention is an abundant polyuria. The patients urinate as much as four quarts a day, and are seized with great thirst. Dyspeptic symptoms set in as the consequence of renal insufficiency, which always exists at the same time. The tongue is dry, and vomiting is frequently present. Locally the bladder is found enormously distended, presenting the form of a large and smooth tumour. The position of the patient is grave, both the ureters and the kidneys are distended with probable renal insufficiency as the result.

Every antiseptic precaution should be taken in treating such patients, as infection is imminent.

The urine should not be completely drawn off, otherwise hematuria might be provoked, followed by coma and death.

The therapeutical indication is to diminish the tension of the bladder progressively. The catheter (coudé) should be passed twice a day and a pint only of liquid drawn off. At about the end of a week or ten days the bladder may be completely evacuated and four ounces of a solution of nitrate of silver (1 in 1,000) injected. The catheter should not be left *in situ*.

If by chance hematuria occurred, the pressure in the bladder should be re-established by injecting six or eight ounces of a solution of boric acid. If in spite of precautions taken the temperature went up, the catheter should be left in permanently for four or five days, but plugged, and the patient recommended not to withdraw the plug more than two or three times daily, and only allow a pint of urine to escape at the one time.

Incomplete retention without distension requires a different treatment.

In such cases the urine stagnates, leaving in the bladder a residue of four or five ounces. The signs of this retention are as in the preceding case, incontinence. It is not rare to see patients urinate a quart in the night. The patients become wasted, pale and suffer from, troubles of digestion. Such persons have been more than once treated for cancer of the stomach. If the urine becomes infected, fever sets in in a remittent form. The malady may last years, but it exposes to vital and local danger renal infection and sclerosis of the vesicle muscle.

The treatment varies with the cause. In case of stricture, internal urethrotomy should be performed and where the prostate was at fault it should be removed if the condition of the patient permitted, otherwise the catheter should be employed three times a day, followed by antiseptic injections.

These patients can live a long time, provided they are properly treated.

Complete retention is the inevitable accident waylaying all patients with hypertrophied prostates. Not being able to urinate without a catheter, these patients relieve themselves at every moment without any regard to cleanliness. They carry their catheters in their pockets, and wet them with saliva to make them pass. Infection is frequently the result of this ignorance of antiseptic rules.

The treatment of complete retention consists in the use of the catheter as often as necessary with washing-out of the bladder. Where possible, prostatectomy should be practised; it allows the vesical contractibility to return, although the vitality of the muscular fibres seemed to have been compromised by years of retention.

Treatment of Burns.

Bathe the parts first with
Picric acid, 1½ drachms;
Sterilised water, 1 quart.
Then spread on salol gauze the following ointment:—
Stovain, 10 grains;
Salicylic acid, 1 drachm;
Dermatol, 1 drachm;
Ess. of thym., 5 mm.;
Vaseline, 4 ounces.
The ointment should be diluted with oil of sweet almonds if the burns are extensive.

GERMANY.

Berlin, Aug. 19th, 1906.

Diseases of the Blood.

At the Society for Innere Medizin, Herr Mosse spoke on this subject. He said the normal anatomy of bone marrow from the 14th to the 16th year showed a network in the meshes of which fatty tissue was embedded, whilst the nodules were cells containing hæmoglobin, and others free of it, the latter with few granulations (basophile, neutrophile and eosinophile) and the lymphocytes. These large cells with basophile protoplasm with commencing formation of granulations and large nuclei, the so-called megaloblasts of mother cells. These large bone marrow cells, with neutrophile protoplasm, of the significance of which we were in ignorance. The hæmoglobin containing cells and those free from it sprang not in common from the megaloblasts, but as the red blood corpuscles as well as the white originated from themselves, there were various stem cells present.

We were acquainted with only circumscript and diffuse diseases of the blood. To the first the myeomata belonged; in these were found erythrocytes, lymphocytes, and myelocytes.

Among the diffuse diseases was pernicious anæmia, with polycythæmia and change of some cell forms (megaloblastic degeneration of bone marrow). Then ordinary anæmia and chlorosis; here there was no definite characteristic condition in the bone marrow.

Then the diseases of the white blood corpuscles; increase of the neutrophile polynuclear cells; increase of all other cell groups in myelogenous leukæmia. The diseases of other organs consisted in the passage of myelocytes through the circulation and consequent metastasia in the organs. In contrast to those conditions was the increase in the lymphatic portion of the bone marrow, the lymphocytes—lymphatic leukæmia. In pseudo-leukæmia there was an almost normal condition of the blood, only some increase in the lymphocytes. There was also, however, a myelogenous pseudo-leukæmia with megaloblasts. After anæmia an aphasia of the bone marrow took place.

Treatment.—Anæmic and chlorotic cases were generally treated wrongly; we did not allow them to rest sufficiently. A longer rest in bed assisted very much.

Pernicious anæmia demanded a hygienic, dietetic therapeusis. In leukæmia the X-rays were to be used, through their use the sources of the cells degenerated.

At the Freie Vereinigung der Chirurgen, Exz. Bergmann related a case of

Operation for Diverticulum of the Œsophagus.

It was the first opportunity of the kind he had had since 1887. The patient who was sent to him with the diagnosis "struma" had a tumour on the right side of the neck, which as she herself observed, swelled on eating, and was emptied by pressure. On sounding the œsophagus, the sound constantly passed into the diverticle; only once did it pass direct into the stomach. After giving bismuth porridge, the diverticle was plainly visible through the X-rays. By this a correct notion of the size and situation of the diverticulum was obtained before operating. The sac was readily peeled out and the sutures readily applied. The wound healed so readily that the patient was able to swallow food on the fifth day.

Herr Sticker spoke on

Recurrence in Carcinoma.

He first discussed the question whether carcinoma could be propagated by implantation, and declared that it could. That carcinoma was transmitted by transplantation of cancer cells was no longer doubted. Spontaneous implantation and post-operative implantation were not the same.

From experiments made with a specially transmissible sarcoma from the vulva of a bitch, he had arrived at the following conclusions:—If several germs were implanted into an organism several grew. If carcinoma was already present at one spot and a second germ was implanted at another spot, the implantation would not succeed. If the first tumour was extirpated, the implantation at the second spot would be successful. If a portion of the first tumour was left behind, this would grow, and implantation at a second spot would be unsuccessful. The cause of this peculiar behaviour he believed to be that in the immediate neighbourhood of the tumour there was a zone of toxines, whilst further away was that of the antitoxines that rendered a successful implantation of germs impossible.

From the experiments made it followed that inoculation carcinoma originated more readily when, in operation, all disease was completely removed, than when such removal was incomplete. In any case the experiments taught that there was a possibility of setting up inoculation carcinoma during removal of the disease, that this should be kept in mind, and that the rules for avoiding such an occurrence given by Winter, among others, should be observed.

Herr Newhaus said that from his own experiments he was inclined to believe that inoculation carcinoma was often in reality multiple carcinoma, and he thought the experiment carried out by the giver of the address being made with a peculiarly infectious tumour did not quite afford any positive proof.

Ecz. v. Bergmann observed on this point that multiple carcinomata were exceedingly rare occurrences.

AUSTRIA.

Vienna, Aug. 19th, 1906.

PYOCYANINE IN LA GRIPPE.

ESCHERICH at the Gesellschaft gave his experience of B. pyocyanine in the treatment of nasal catarrh, etc. The drug was a powerful bactericide and disinfectant. Properly it may be designated a proteolytic enzyme, which Emmerich and Löwe have named "Nukleasn," obtained from B. pyocyaneus by a sort of autolytic process in the protoplasm. This new substance, by whatever name, has the power of acting locally as a powerful disinfector. Escherich has used this preparation since autumn last in the form of a spray with wonderful success. He is not satisfied that it will destroy the diphtheria bacteria in the fauces, but it certainly destroys all the catarrhal forms in the fauces, and is therefore an excellent local disinfector. Pfeiffer's micrococcus catarrhalis is destroyed in the fauces by five drops of pyocyanine passed in through the nasal cavity. Meningo-coccus disappears from the throat with the same rapidity when the preparation is used. This has led to the conception that injections of pyocyanine into the cerebro-spinal canal would modify or evert meningitis. Following this train of argument, Escherich commenced intradural injections of three to five cubic centimetres of pyocyanine, with a decided diminution in the intensity of the disease, and complete disappearance of the meningo-coccus from the cerebro-spinal fluid when withdrawn by the aspirator. It often occurs that when the meningo-coccus disappear from the nasal secretions the meningitis is everted and the child escapes from this fatal disease.

FIBROMA OR GLIOMA IN CORD.

Erben presented two cases with paralysis of arms from different reputed causes which often lead to confusion in diagnosis. The first was attributed to wearing a strap over the arm in carrying his case of tools. One day he was more loaded than usual when one of the straps gave way over the left shoulder, allowing the heavy case to swing round, locking the right shoulder and unduly pressing the clavicle against the spinal cord and first rib, and crushing Erb's point as well as the plexus in the arm-pit. Four days after this accident the right arm fell helplessly by the side. The brachical plexus seems to have been involved. The triceps, radial nerve, and later the pectoralis were quite obsolete. Here it appeared we had peripheral combined with the central paralysis tending to confuse the issue.

In the second case the paralysis commence gradually in the neck and shoulder muscles on both sides of the body, as well as the upper parts of the right arm. The paralysed muscles had a fibrillary movement, pointing to the anterior horn of the cord, resembling the humero-scapular type. There were also contractions of the upper arm of the "Primâre" nature, indicating a central irritation in the motor centre. From the loss of muscular power, it was strong proof that the roots in the cord were primarily affected. No bone or meningeal defect could be observed or suspected and therefore left no other positive result than some intramedullary growth or morbid change. This case was three years under observation and very little change could be perceived, which demonstrates the slow growth and the suspicion that the change was due to tubercle, fibroma, or glioma, but probably the latter lying somewhere between the second and eighth segment of the cervical region.

CERVICAL FORM OF SYRINGOMYELITIS.

Flesch records a very interesting case of syringomyelitis, commencing eight years ago with the loss of feeling in the left hand for cold. The patient was a merchant, æt. 28, who was early affected with atrophy of the muscles of a central character. Half a year ago the skin was covered by a form of ichthyosis or accentuated psoriasis more severe over the extremities. After two months the psoriac patches began to fall off, leaving brown pigmented patches not elevated, nor thickened, but having a normal sensibility. The histological examination proved the absence of any parasitic origin.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

COMPLIMENTARY RECOGNITION OF SIR A. R. SIMPSON.—By way of public recognition of Sir Alexander Russell Simpson's work and worth it has been resolved to raise a fund for the endowment of a bed in the Maternity Hospital, for which a sum of £1,000 will be required. A large and influential committee has been formed for this purpose, the chairman being Baillie W. S. Brown, Edinburgh, while among the vice-chairmen are Lord Overtoun, Sir William Turner, Sir John Halliday Croom, Dr. Playfair, Mr. Macgillivray, Dr. Affleck, Dr. Berry Hart, Dr. Ballantyne, and Dr. Ritchie. In their appeal the committee believe that the opportunity of showing this appreciation of Sir Alexander Simpson will be welcomed by practitioners in other lands and in our own land who remember him as a gifted teacher and a kind friend, by many who have grateful remembrance of his skill, by his fellow-citizens, his comrades in Christian service, as well as by others belonging to a wider circle. It is felt that this appreciation would not be appropriate to the character of one whose life has been a signal example of unselfishness, unless its primary purpose were to confer a benefit on others, especially on the poorer classes. Any sums contributed beyond what is necessary for the endowment of a bed will be used in making a personal gift to Sir Alexander and Lady Simpson, or in such a way as may be agreeable to them. It is hoped that the presentation will be made early in October, as Sir Alexander Simpson proposes about that time to visit mission stations in India and China, and afterwards to attend an important Christian conference in Japan. Contributions to the fund may be sent to Mr. John Nicholson, manager of the Clydesdale Bank, George Street, Edinburgh.

BELFAST.

"TEMPERANCE SUMMER SCHOOL" AT PORTRUSH.—A new movement in the interests of temperance reform has been started this year in the shape of a conference, or "Summer School," which has been held during the past week at Portrush. At the opening meeting the chair was taken by Miss Richardson, B.A., one of a family which has been for years identified with temperance and social reform at their model village of Bessbrook, co. Armagh. For four days there were frequent meetings, and a number of lectures and addresses were given on the scientific and social aspects of the temperance question, several medical men taking part. On the first day Dr. Watson, of Bloomfield, Belfast, read a paper on "The Handy Drug." He dealt specially with the common use of alcohol as a household remedy for all the ills that flesh is heir to, and argued that this was often the foundation of a taste for alcohol which produced disastrous results in later life. At the

best, he believed it to be a drug of doubtful qualities and many dangers, and he longed for the time when only the curious antiquarian might be heard to ask, "What is whisky?"

On the third day Major Jackson, R.A.M.C., Cork, gave an address on "Temperance in Relation to Hygiene." He spoke specially of individual responsibility for the improvement of our sanitary surroundings, which we are too much inclined to leave to the State or municipal authorities, and among such personal efforts he placed the promotion of temperance in a foremost place. On the same day, Dr. Norman Barnett, Belfast, read a paper on "Temperance Legislation from the Medical Standpoint." He said he wished to discuss, not those acknowledged insane as the result of alcoholic excess, but the chronic "drunk and disorderly." He pointed out the effects of alcohol on the white corpuscles of the blood, and on nerve tissue, and said that as a result of long indulgence these cases became incapable of keeping themselves clear of alcohol. They were usually given short terms of imprisonment, as if they were reasonable beings, but he argued that recent research had shown that their nerve cells were so degenerated that they could not be considered as such. An injustice was thus done, not only to the man himself, but to the State which had to support him, and to those dependent on his support, who might have to fall back on State support also.

On the closing day, those attending the "school" were hospitably entertained by Lord Macnaghten at a garden party at his beautiful place, Runkerry, close to the Giant's Causeway. The movement seems to have been a great success, and will no doubt be repeated another year.

Public Health.—The Public Health Committee of the Corporation has come to the conclusion that gentle persuasion has failed to prevent people throwing waste-paper, orange and banana skins, broken glass, &c. in the street, and they have therefore drawn up a code of bye-laws for the better prevention of such nuisances. The idea is excellent, if only the bye-laws are enforced, but past experience leads us to fear that their publication will afford some occupation to printers and bill-stickers in the dull season, and end there. An outbreak of typhoid in the south side of the city, in one of the best and supposed most healthy residential districts, has caused some anxiety. So far the cause of the outbreak has not been traced.

Larceny from Queen's College.—A porter of the Chemical Department at Queen's College has just been committed to prison for four months for the theft of a quantity of platinum. He abstracted some small vessels entire, but the larger ones he simply pared down round the edge, rendering them a little shallower. It is easy to see that such a process, carried to a moderate length only, might prove very hard to detect. The total quantity taken in this case seems to have amounted to about £70.

LETTERS TO THE EDITOR.

THE SUPPRESSION OF QUACKERY.

To the Editor of the Medical Press and Circular.

Sir,—The letter of Mr. Henry Sewill, published in your issue of August 15th, contains a munificent offer, and it is to be earnestly hoped that others may come forward in the same way. Might I suggest the opening in your columns of a subscription list to help? Mr. Sewill's object is a great one, it is to suppress every form of quackery. I have done my best to aid in the suppression of one special branch of charlatanism—the aural quack. Recently a series of most disgraceful advertisements appeared in the *Daily Mail*, in which a well-known and oft-exposed aural quack, "Professor" Keith-Harvey, laid ingenious traps for deaf sufferers. After repeated letters to the Editor I at length succeeded in getting these "ads." suspended during investigations. I was able to help the latter by the ready assistance of the Editor of *Truth* and Mr. Evan Yellon, the author of "Surdus in Search of his Hearing," one of the best and most courageous of exposures of aural quackery ever made. The Medico-Political Committee of the British Medical Association are taking this Keith-Harvey matter up, and I hope it will be able to achieve something.

What is wanted, however, as Mr. Sewill points out, is a stringent law, rigorously executed, and if professional apathy could be overcome, doubtless such a law could be obtained. I would further suggest that the Medical Press and Circular should draft a petition, confined to the medical profession, asking for a Royal Commission.

The absurd discussions upon matters medical which we see every day in lay papers help the quacks largely. As an instance, I would quote the half column of fervid nonsense in a reputable paper to-day, stating that a "well-known medical specialist" says that motoring will do away with kissing. Personally, I do not believe that any medical man in the United Kingdom would make such an absurd statement and my unbelief is strengthened by the following fact:—Last year I was consulted by a journalist working for this very paper. In the course of some general conversation, I asked him if he could tell me who the "well-known Harley Street specialist" was who was so fond of airing his views in the paper in question. He laughed, rubbed his hands, and said, "It's mostly *me*."

It may interest your readers to know that the "Drouet Institute" people, so thoroughly ruined by *Truth's* "ruthless exposé," have started operations again. They have taken a place in New Oxford Street, and have re-named themselves "Aural Clinic, Ltd." I am communicating this fact to *Truth*.

I am, Sir, yours truly,

Macleod Yearsley, F.R.C.S.
Senior Surgeon to the Royal Ear Hospital.
10, Upper Wimpole Street, S.W.

To the Editor of the Medical Press and Circular.

Sir,—Twice within the last year or so—once within the last few months—one of the most widely advertised of the quack medicines of the day has been denounced by Judges of the High Court as an impudent fraud. Advertisements of this nostrum, which, after the last trial ceased for a time to appear, have now again begun to be published in the leading London papers. It must be assumed that the astute men of the world who own, edit, and manage the journals in question are not aware of the character of the trade which is being carried on, and can be successfully carried on only with their help. These censors of political and private morality would no doubt be amazed, shocked, and confounded if made to realise their position in this matter. If quackery is to be suppressed the first step must surely be to enlighten these gentlemen and the intelligent public with regard to its nature and effects. It ought not to be beyond the powers of our profession, acting together, to bring the facts into the light of day by means of a Parliamentary Commission or otherwise. If the men who hold leading positions will come forward there need be no doubt about the backing they will command from the bulk of the profession.—I am, Sir, yours truly,

An Obscure Practitioner.

August 15th, 1906.

To the Editor of The Medical Press and Circular.

Sir,—I always admire a man who is willing to back his opinion by practical support. Your correspondent, Mr. Henry Sewill offers to subscribe £50 if ninety-nine others will contribute a like amount as a nucleus for organising and presenting evidence before a Royal Commission for the suppression of quackery. I might not be able to subscribe so large a sum myself for the benefit of the many, but should be glad to contribute towards so desirable an object. I fear, however, it will be considered by some as "utopian," and by the majority of the profession as "not their business."

Personally, I do not agree that it is not our business to protect an ignorant public from the cruelty and rapacity of quacks, but the great majority of us have in the past so persistently ignored our common interests and disregarded the entreaties "to move," when urged by the energetic appeals of yourself and the editors of other medical media, that I for one despair of the chances of success of your correspondent's effort for the suppression of quackery.

I am, Sir, yours truly,

J. WILSON.

August 15th, 1906.

THE TREATMENT OF PHTHISIS.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—Does it not appear reasonable to most of your readers that we must look to climate as more important than any other therapeutic agent in the treatment of phthisis? Those who have had opportunities of judging of the influence of climate would be conferring great benefits if they would give the results of their observations to the profession, through which the public would derive so much benefit. There are many in this country who would do well to leave us for one of our great Colonies—Canada, Australia, or New Zealand. We cannot change the climate of our own country, and it is probable that very little, if any great change in the mortality from phthisis will be obtained from any of the many new plans that have been brought forward lately for its relief.

Our population is increasing to such degree that emigration must be looked to more than anything else to relieve it, and it would be well if some guidance could be given by the profession to those who are anxious to leave us, and find a country where the climate would make their lives useful and contented. There is some fine climate in Australia along its Southern coast, or in the north island of New Zealand, while Canada is a country which offers various and great advantages in the matter of health. Might I suggest that your columns may be the medium of widening our knowledge of what our Colonies offer in respect to health, and that the present state of ignorance may be changed to one of accurate and reliable knowledge for the great good of many.

I am, Sir, yours truly,

ROBERT LEE.

THE FALLING BIRTH-RATE.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—The birth-rate in England and Wales continues to fall steadily. During the three months ending June last the rate is the lowest recorded in the second quarter of any year since the establishment of civil registration, and is 1·6 per 1,000 lower than the average rate for the corresponding three months of the ten years 1896–1905. This subject, as it deserves—has formed a frequent theme for editorial discussion, and has from time to time excited animated controversies in your columns. The fact seems clearly established that the fall in the birth rate is not due to natural causes, but to the deliberate action of married couples in preventing conception. This fact was also proved in the enquiry carried out by the Government of Victoria, Australia, a year or two ago. It is notorious that the stagnation of population in France is due to the same cause, and it is not doubted that the diminishing birthrate in most of the other countries in Western Europe and in the United States is being brought about by similar means. Whatever may be the ultimate effect upon the moral and physical development of the race there can be no doubt that empire will depend upon population, and that nations in decay are at this epoch as surely doomed to be gradually supplanted or conquered by more virile races as they were in the old days when the barbarians came down upon Rome. For thirty years the population of France has remained at 38,000,000, a much smaller number than there is room for on her fertile soil, and she has no men to send to vast oversea possessions, misnamed Colonies, which she has in later years acquired. On the other hand, Germany has 61,000,000 in the Fatherland, and her numbers are increasing by nearly a million a year. The whole British Empire, as has been lately pointed out, contains only 55,000,000 of people of white or European blood. If we do not become prepared to people our Colonies, is it likely we shall be allowed for ever to hold them? With the example of France before us, and with this exemplification of the rapidity with which a great people can deliberately and out of pure egoism destroy its position among the imperial powers, it must be admitted that the population question calls for the serious consideration of our statesmen, and of all those who believe that the establishment of a truly mighty British Empire is necessary for the continual advancement of the whole world along the paths of high civilisation, along which, as we flatter ourselves, we have already made such notable progress.

I am, Sir, yours truly,

August 16th, 1906. IMPERIALIST.

ETHICS IN PRACTICE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I have always had a keen admiration for the manner in which your paper upholds the ethical purity and the dignity of our profession. We are living in an age of strenuous competition, and I am afraid that the result is a lowering of our ethical standards. We must win over to our confidence the laity; we must impress upon the public our own personal merits, and, still more, the demerits of our colleagues. In a word, we must "go one better" than our colleagues. Now, if this meant that we intended to excel by devoting more time to the study of our work, and so leave the laggards behind, I should be the last to complain. Unfortunately, this is not the case. It is a case of snapping another man's patients when the other man has his back turned, and saying nothing about it: or, as in the case upon which you comment, adding a string of meaningless letters, such as M.B., B.A., after your name, meaningless to the members of the medical profession, but possibly full of meaning to the laity. With you I hope and trust—as many other right-minded members of our profession also hope—that the local medical men of the town in which this member resides will act promptly and energetically, and will teach him that he belongs to a noble profession, the majority of the members of which will not tolerate such behaviour. Have we not been pouring out the vials of our wrath upon a more or less uneducated class of women who, in ignorance which is pitiable, flaunt after their names such letters as L.O.S., C.M.B., in the hope of deluding their too often ignorant victims into the idea and belief that they hold some medical qualification?

It is high time after such declamations against those who are outside our profession, that we begin to review the conduct of our own colleagues, and, having so glaring a case of the assumption of meaningless letters as the one mentioned in your current issue, that we prove to the medical world and the world at large that we shall not tolerate such snobbery in our ranks, and remind offenders that *magna est veritas et prevalibit.*

I am, Sir, yours truly,

SPES.

CREATED ABSCESSES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The reading of your Paris correspondent's article on above subject reminded me of this case, which happened some years ago: A prepossessing young lady, about eighteen or nineteen years of age, had a large-sized gland, hard and fixed, in side of neck. Her father brought her for my opinion, as he was told "it must be cut out." I reasoned, if I could turn the gland into an abscess, and, when ripe, let out the contents by small incision or aspiration, the neck would show no ugly mark. I told the patient, if she could bear pain

well. I would try and cure the "lump" without cutting. I injected a hypodermic syringeful of spts. turpentine (and the pain produced was so severe I rather regretted having done so, but prescribed hypnotic to be taken regularly to keep pain in check, and hot poppy-head and cammomile stupe to be used each night before retiring). In about a week abscess was ripe, and I evacuated the contents—about eggcupful. No mark visible after a few days. Having seen the good results in this case, I tried it in another, with equally successful ending. The only two cases I have treated; and as two cases could not prove much I should not have written but for seeing your correspondent's remarks. I should think in cases of tubercular glands, the injection of turpentine or spts. ammon. aromat. would produce abscess without risk, and leave little or no mark when opened by small incision.

I am, Sir, yours truly,

Alexander Duke.

London, W.

SYPHILIS AND TUBERCULOSIS.

To the Editor of the Medical Press and Circular.

Sir,—There is a singular attraction for some of us in the study of disease, as one of the most active and injurious forces that influence the development of human life and happiness.

From what source any disease may spring, and how it may act on the human species, may take up the whole thoughts and spare time of some of us, and, probably, no scientific problems bring more satisfaction, when solved than the discovery of the nature and origin of any disease which has inflicted suffering, and the prevention of which is the means of saving human life.

In carrying on this kind of investigation we must be careful to keep our minds clear of theory in every form, and by theory I mean the influence of imagination, and errors of observation.

Some of us are working for what we call principles; some of us are contented to accumulate facts, and leave these alone till they have arranged themselves in some order, and work out their own laws or principles for themselves.

The chief object that I have in writing this letter to you is to consider the last paragraph in the lecture that was published in the Medical Press and Circular of August 8th, and was given by Mr. Hutchinson at the London Hospital on the Connection between Tuberculosis and Syphilis. In that last paragraph Mr. Hutchinson tries to lay down certain "principles"; and as I think these are not founded on facts, they ought not to be allowed to influence those who are engaged in the practice of our profession.

As far as I can conceive of what is meant by the word 'principle" in scientific work, I should say we mean what in mathematics or physics we should call a "law" or "theory."

What Mr. Hutchinson wants to lay down as a principle is that if any one has a tendency to tuberculosis, and then is infected with syphilis, the consequences will be modified, that is to say, the symptoms, &c., will probably differ from those which would be observed in a case where there was no tendency to tuberculosis.

Now, in regard to hereditary syphilis, no evidence can be brought forward in support of any definite opinion on the question; Would a tuberculous infant who inherits syphilis show any different symptoms from those where the child did not inherit tuberculosis? Syphilis is not a definite disease, for the simple fact stands out as clearly as possible, and of this Mr. Hutchinson seems either to be ignorant or unable to understand. The syphilitic symptoms vary in infants and young children according to the state of the father's or mother's health at the time of conception, that is, the stages through which the syphilitic infection had passed. I tried to put before the profession some years ago in the lectures I gave at the Great Ormond Street Hospital, and which were published in the Medical Press and Circular, the results of many years careful study of infantile syphilis. Between 700 and 800 cases passed under my care and I allowed no "theories," and no "principles" to influence me in the study I was pursuing.

If Mr. Hutchinson had impressed upon the students at the London Hospital that syphilis is not a definite constant like variola or scarlatina, it would have been far better than to tell them what is not true, that "the virus, in all probability is always the same." He might have told them how Dr. Cory fell a victim to this error, and how he vaccinated himself with syphilis. Dr. Cory was an old friend of mine, and I was indeed sorry that his ignorance or wrong "principles" led him into such sad trouble. He and Mr. Hutchinson and John Hunter and many others somehow are always under the influence of theory, and won't look at facts that go against them.

I am, Sir, yours truly,

Robert Lee.

OBITUARY.

W. J. MARTIN, M.D.

Much regret has been caused in Dublin by the death at his residence of Dr. W. J. Martin, of Harcourt Street, an old and very highly-esteemed member of the medical profession. Dr. Martin was the son of the late Mr. James Martin, Cappagh, County Dublin, and brother of the late Sir Richard Martin, Bart., of Merrion Square. Dr. Martin, who was connected with Jervis Street Hospital for close upon fifty years was qualified physician at the age of 21, and amongst the appointments which he held were Inspector of Anatomy for Ireland, Surgeon to Richmond Asylum, and Fellow of the Royal Academy of Medicine. At the last meeting of the Committee of Management of the Richmond Asylum, the following resolution was, on the proposition of the Chairman, carried unanimously:—"The Joint Committee of this Asylum have learned with unfeigned regret of the sudden demise of Dr. W. J. Martin, Visiting Surgeon, an old and loyal officer of the Institution. During his long service of twenty-five years he enjoyed the warmest esteem of the Board and staff of the Asylum, his amiability and kindness to the patients securing him an affectionate regard. We wish to convey to Mrs. Martin and family this expression of our sincere condolence." The Chairman also referred sympathetically to the fact that Dr. Martin had been on duty the day before his death.

A. E. CURTIS, M.B., C.M. Edin.

We record with sorrow the death at Cheadle, near Stockport, on August 11th, of Dr. A. E. Curtis, formerly of Sheffield. He was 43 years of age. For a number of years he was in partnership with Dr. Reckless, at Broomgrove Road. Five or six years ago Dr. Curtis took up practice at Infirmary Road, but in May last year an unfortunate illness necessitated his retirement. Latterly he removed to Cheadle. A more kindly, generous and attentive medical practitioner there never was, and the appreciation of his worth and good nature went far beyond his professional sphere. He was interested in sport and was frequently to be seen at football and cricket matches. In musical circles his severance from Sheffield was keenly felt. He possessed remarkable vocal powers, and was a valued member of the Choral Union.

At the half-yearly court of governors of the East London Children's Hospital, Shadwell, it was reported that a donation of £3,000 had been received from the Zunz trustees and a legacy of £7,000 under the will of the late Mr. Thomas Crockett, of Droitwich.

REVIEWS OF BOOKS.

INTERNATIONAL CLINICS (*a*).

THE present volume of this quarterly journal contains as usual a number of papers and clinical lectures on therapeutics, medicine, surgery, pathology, and some of the medical specialities. Most of them are interesting and readable, but are only of ephemeral interest, but a few of them deserve more than a passing attention. Out of the twenty-five separate contributions which make up the volume the most valuable in our opinion is that by Dr. Corner, of London, on Post Operative-Neurasthenia. The condition to which he calls attention must be familiar to all surgeons and physicians in large practice, but up to this only one or two have taken the trouble to point out its existence, while many surgeons we believe are accustomed to dismiss, more or less contemptuously, those patients who still complain of unpleasant symptoms after the cause of such has been apparently completely removed, forgetful of the fact that they have been dealing with a living body and not with a physical machine. To such surgeons we strongly recommend this paper. In it Dr. Corner points out that the neurasthenia phenomena may exist in very different degrees, and also remarks that many patients should be studied carefully with reference to their nervous equilibrium, before any operation is undertaken except in cases of absolute necessity. The severity of the operation is not the only thing to consider, for in many individuals the dread of an anæsthetic may prove more potent for ill than even the fear of the knife and the subsequent pain. As a fact Dr. Corner has observed typically neurasthenia symptoms after such simple procedures as hernia operations, as well as after more extensive operations. Another paper to which we would claim attention is that by Dr. Warkin on the Effects of X-Rays upon the Blood-Forming Organs. This is a subject which has lately attracted a great deal of attention, and it is here dealt with in a most comprehensive manner. The paper in fact constitutes, we think, the most complete summary of the subject as far as present knowledge goes, in the English language. A second interesting contribution under the section in Pathology is that on Eosiniphilia, by Charles Simon. The paper is historical as well as experimental, and brings together most of the accepted knowledge on the subject, as well as adding one or two new points. Space forbids us to do more than mention the paper on "Cysts of the Lesser Peritoneal Cavity," and that on "Post-Tussive Suction." Both are interesting and suggestive and, along with those already mentioned, make the volume well worth purchasing.

VOLUME I. of the sixteenth series of International Clinics, contains, as is customary, a review of the progress of medicine and allied sciences during the past year. This is, we think, its main claim to be of value, and we may at once state that in our opinion it is the most important part of the present book, although it only constitutes about one hundred out of three times as many pages. Its very brevity, indeed, is strongly in its favour, both because it is in contrast with the other very extensive reviews that are published and which for the most part are too lengthy to be read with profit, and also because the shortness of the space devoted to it renders necessary a very careful consideration as to what should and what should not be included. The result is that it embodies almost every important advance without giving a tedious précis of every paper good and bad that has been published during the year. Last year we were very much impressed with the surgical review as compiled by Dr. Bloodgood, of Baltimore, and this year we can extend to it almost the same degree of praise, while adding that the summaries of therapeutics and medicine are in our opinion much improved, and are almost of equal merit with the surgical one, except that the compilers have failed to give to them the personal tone that is so important for the preservation of interest in the subjects discussed. The remainder of the volume includes seventeen contributions from authors of several different nationalities. The best of them is that by Dr. Battle on "The Effects of Quiet Renal Calculus," and is a paper well worthy of careful study. The rest of them are of no special interest, and do not call for any comment.

(*a*) "International Clinics." Vol. IV., 15th Series, and Vol. I., 16th Series 1906. Philadelphia and London: J. B. Lippincott and Co.

SCUDDER ON FRACTURES (*a*).

"The Treatment of Fractures," by Dr. Scudder, is another of the admirable books with which Messrs. Saunders and Co. have enriched medical literature of late years, and which are essentially practical in nature. We feel that the publishers deserve peculiar gratitude for the lavish way in which they prepare the books they present to the profession. The volume before us contains 739 illustrations of exquisite workmanship—radiographs, half-tones, and diagrams—which leave one wondering if it is possible for reproductions in the future to attain a higher degree of grace and realism combined. In thus thanking the publishers we by no means intend to detract from the credit due to Dr. Scudder and his associates, for of their work it is impossible to speak too highly. Indeed, it seems to us that the publishers are as happy in their author as the author is in his publishers, which is another way of saying that an organised combination of author, illustrator, and publisher has in this, as in other cases to which we have referred lately, produced work of the highest class. The various fractures are depicted in well selected radiographs, the external appearances of the injured parts are reproduced in no less excellent half-tones, whilst such graphic photographs of each step in the reduction and fixation of each fracture are given that it would seem the easiest matter in the world to diagnose and treat a breakage in any part of the human body. If we take, for instance, the question of injuries about the elbow-joint, we find two beautiful drawings of the bones of the elbow, and photographs of the normal appearance of the joint and of the methods by which the joint may be examined. Next, there are twenty drawings and diagrams of the different fractures of the bones about the joint; three photographs of actual patients suffering from such fractures; twenty-six radiographs of fractures about the joint; and twelve photographs and drawings of methods of reduction and of application of splints. All the other regions are treated with an equal prodigality of illustration. A valuable chapter is written on the employment of plaster-of-Paris, and each step in the process of the preparation and application of plaster to different regions is displayed in photographs of great clearness, no less than thirty-five being reproduced for the purpose. Some notes on dislocations, again illustrated by photographs and radiographs from living subjects add not a little to the completeness of the volume, but the dislocations are not treated with the same fulness and circumstantial detail as the fractures. So prominent a feature do the illustrations of this book constitute that one is apt to assign a secondary place to the text. This, however, is written with care and judgment, and as the outcome of the experience of an American surgeon to a large hospital, it will have a special interest for medical men in this country. The style is brief and business like, and not without an attraction of its own. Tedious detail does not encumber the descriptions, and there are but few records of cases. Those that are included, however, are worthy of their place. A little-known injury, stated not to be very unusual in young adults, is described and illustrated on pages

(*a*) "The Treatment of Fractures." By Charles Lacke Scudder, M.D., Surgeon to the Massachusetts General Hospital. 5th Edition. Thoroughly revised. 739 Illustrations. Philadelphia and London: W. B. Saunders and Co., 1905. 21s. net.

385 and 387. This consists in the starting and projection forward of the upper epiphysis of the tibia, and is said to be often associated with apparently trivial injuries. The radiograph which is reproduced to illustrate the condition leaves no doubt as to its actual occurrence. We are naturally inclined to criticise some of the views expressed by the author—such, for instance, as that massage and passive movements should not be begun till the second week after a Colles' fracture—but we can say without reserve that in the main they are as sound as they are clearly expressed. This book will be found of great use by general practitioners, especially such as have but few cases of fracture occurring in their practice, for in it they will find lucid descriptions and illustrations of every breakage they may be called upon to treat, and of the way to manipulate and apply their splints. To the hospital and colliery surgeon it will be a mine of wealth, and, as in itself a thing of beauty, it will be a joy for ever.

ALLGEMEINE PATHOLOGISCHE-ANATOMISCHE DIAGNOSTIK.(*a*)

A certain knowlege of the naked eye appearances of morbid tissues is nowadays regarded as a part of the necessary equipment of a medical man. It is regrettable that in this country such knowledge, so far as it is required for examination purposes, takes the form of an acquaintance with museum specimens, which have lost many of the characteristic features of the fresh tissues. It would be a great advantage to the student if a part of the patient and careful teaching which he receives from the anatomist were devoted to training him in the systematic observation and description of the appearances of normal fresh tissues.

The book which is the subject of this review is intended to develop a systematic scheme for the examination by sight and touch of the organs and tissue of the body *post mortem*. By the use of such a routine the pathological diagnosis emerges of itself at the close of the examination, which is the only sound method of arriving at it.

The division of the subject naturally falls into a macroscopic and a microscopic portion, of which the former is by far the most important for the English reader. We have in English many good books on microscopic pathology; there is none which contains a description of naked eye appearances so full, clear, and simple as that which is to be found here.

The first section is on the method of investigation, and here we have general rules for the accurate observation of the size, shape, and consistence of organs, the colour degree of moisture or dryness, of smoothness or roughness of surfaces.

Then follows an admirable chapter on the causes of death, which should be studied by everyone who has to make a *post mortem*. The immediate causes of death are divisible into those which concern the heart, the lungs, and the brain. The signs by which each of these may be recognised are clearly and fully brought out. We have then an account of the general methods of macroscopic diagnosis of various pathological conditions, circulatory disturbances, exudations, forms of degeneration and necrosis, ulcers, tumours, etc., and the macroscopic portion of the book ends with a description of the examination of the special organs and tissues, giving very briefly the technique of the *post mortem* examination in each case, and going into some detail on the commoner morbid conditions. All through the system laid down in the earlier chapters is followed out, the variations in the size, consistence, etc., being dealt with for each organ.

The microscopic portion is chiefly valuable to the English reader for the details given as to the appearance of fresh sections. It covers the same ground as O. Israel's book on pathological histology, but the absence of illustrations makes it less interesting to the general reader. Here, again, the general chapters, dealing with the various forms of cells and intercellular substance, are excellent. The book is primarily one for students, but it contains much that will be found useful and interesting by any medical man.

(*a*) "Allgemeine Pathologische-Anatomische Diagnostik." Von Dr. K. Oestreich, Privat dozenten an der Universität Prosektor des Königen Augusta Hospitals zu Berlin. Verlag von S. Karger, Karlsrasse, 18, Berlin.

DEMONSTRATIONS OF ANATOMY. (*a*)

A volume that has reached a twelfth edition, and that has in its previous editions been familiar to successive generations of medical students, needs little recommendation by the press to prove that it is worthy of taking its place among the standard text-books of human anatomy. The name of the present editor, moreover, bears testimony to the character of the present production. Under the circumstances, therefore, we are in a position to freely criticise, and we will begin with the illustrations. Many of these are reproductions of the celebrated "Illustrations of Dissections" which first saw the light more than forty years ago, while in addition many new ones, partly borrowed and partly original, have been introduced. Many, moreover, have been improved and made more striking by the use of colours for the arteries and veins. Despite all this, however, the eye that has become educated to the beautiful drawings that are to be found in many other English, American, and German text books cannot but fail to notice a lack of that artistic appearance with which it has become familiar. The words "rough" and "crude" come readily to the tongue, while looking at them, and one experiences a distinct sense of disappointment at finding such a reproduction of Dixon and Birmingham's beautiful drawing of the pelvic peritoneum, as is to be found on page 377. We do not mean to state that the drawings fail to represent correctly the proper anatomical position of the structures delineated, for most of them are correct enough, but rather that they are not modern enough in their type and that they are far from artistic. For example, the drawing of the muscles of the outlet of the pelvis on page 382 may have been good enough in the days before formalin came into use, but it is certainly far from pleasing, and we know from personal experience in teaching that many students look upon it as an insoluble puzzle. Again, the relations of the abdominal viscera are very inadequately portrayed, and many of the illustrations of the brain, as, for example, that on page 748, are weak. Proper perspective, also, is wanting in many of the pictures, as, for example, in that on page 466. On the whole, we may say that the best of the illustrations are those which have been borrowed direct, and that few of them have been improved by the borrowing.

As regards the text, we have less to say. Most of it is clear and to the point, and the student who follows it while actually dissecting should find himself enabled to do without the aid of a demonstrator. Dr. Addison's method of marking out the viscera on the surface is that made use of, and also his method of subdivision of the abdominal cavity. Unfortunately, however, some examiners refuse to accept his methods, and this may prove a difficulty in the future to candidates who derive all their anatomical knowledge from this book. We are rather disappointed also to find such little reference to peritoneal compartments, as distinct from peritoneal folds, and we notice also the absence of any reference to the fascia propria of the prostate, and to the renal fascia. Numerous other omissions might be mentioned, but enough has been said to call attention to what we regard as the defects of the book. It has the advantages of being cheap, of comprising the outlines of anatomy in a single handy volume, and of having a very complete list of side references in the pages which facilitate the looking up of any required point.

(*a*) "Ellis's Demonstrations of Anatomy." Twelfth Edition. Revised and Edited by Christopher Addison, M.D., F.R.C.S. Illustrated by 306 wood engravings, of which 75 are in colour. London: Smith, Elder and Co. 1905.

MEDICAL NEWS IN BRIEF.

Doctors in Congress.—British Medical Association at Toronto.

THE annual meeting of the British Medical Association opened at Toronto yesterday, and will continue until Saturday next. Among those who are attending the Congress are the president, Mr. George Cooper Franklin, surgeon, Leicester Infirmary; Sir James Barr, Sir Victor Horsley, Dr. Anderson Griffith, Professor Arthur Robinson (Birmingham), Dr. Norman Walker (Edinburgh), Dr. J. Dundas Grant (London), Sir Thomas Barlow, Dr. Freeland Barbour (Edinburgh), Mr. Marcus Gunn (London), Dr. G. A. Sutherland (London), Professor W. D. Halliburton (London), Dr. Julius Mickle (London), Sir Hector Cameron (Glasgow), and Dr. Donald MacAlister (Cambridge). Two Canadian doctors will act as chairmen of sections—Professor J. G. Adami (Montreal) in the section for patholgy and bacteriology, and Dr. Frederick Montizambert, I.S.O., in that for State medicine. After four days' work, Saturday will be devoted to excursions. The president-elect of the Association is Mr. R. Andrews Reeve, Dean of the Faculty of Medicine, University of Toronto.

The following is the programme arranged for the annual meeting :—

TUESDAY, AUGUST 21ST.—9.30-12.30 a.m., meetings of Sections; 2.30 p.m., address of welcome, introduction of guests, delegates, &c., president's address; 4.30 p.m., in University Quadrangle a reception and garden-party by the president-elect and Mrs. Reeve; 8.30 p.m., address in obstetrics, Dr. W. S. A. Griffith; 9.30 p.m., reception by the Lieutenant-Governor.

WEDNESDAY, AUGUST 22ND.—8 a.m., National Temperance League breakfast; 9.30-12.30 a.m., meetings of Sections; 2.30 p.m., address in medicine, Sir James Barr, M.D.; 4.30 p.m., garden parties; 8.30 p.m., address in surgery, Sir Victor Horsley, F.R.S.; 9.30 p.m., reception.

THURSDAY, AUGUST 23RD.—9.30-12.30 a.m., sectional meetings; 4.30 p.m., garden parties; 7.30 p.m annual dinner.

FRIDAY, AUGUST 24TH.—9.30-12.30 a.m., sectional meetings; 2.30 p.m., general meetings; 4.30 p.m., garden parties; excursions; 8.30 p.m. soirée.

SATURDAY, AUGUST 25TH.—Excursions to the Niagara Power Company's plant, through the courtesy of Sir Henry M. Pellatt; excursion to Muskoka; excursion to Lambton, through the courtesy of the president, Mr. Austin.

Irish Midwifery Qualifications.

IN the House of Commons, Mr. Healy recently asked the Prime Minister whether he was aware that although Dublin contained the largest and oldest chartered school of midwifery in the Empire, and the second largest in the world, the profession of midwife in Ireland, which had been organised for more than 150 years, had been gravely prejudiced by the action of a newly-constituted body in England (which was not yet four years old), in refusing to recognise the Irish midwifery qualification and inducing Government departments to stipulate in advertisements that the new English qualification would alone be recognised; was he aware that the Irish midwifery schools, which now attracted students not only from Great Britain and the Colonies but from the Continent and the United States, had without effect protested against the slur officially cast on the older Irish qualification; would he inquire whether the English Central Midwives Board refused to hold any examination in Ireland (although guaranteed the expense), so as to handicap Irish midwives and put them to the outlay of a ten days' visit to England; and, if so, would the Government allow the Midwives Act, 1902, which was passed with the consent of all parties, to remain in force.—Sir Henry Campbell-Bannerman replied that the Central Midwives Board had not refused to recognise the Irish midwifery qualifications, nor had it induced, or endeavoured to induce, Government departments to stipulate in advertisements that the qualification of its own certificate would alone be recognised. As to the refusal of the Board to hold examinations in Ireland, of which the honourable member complained, he was advised that by the terms of the statute such examinations could not be held in Ireland.

Post-Office Medical Officers at Glasgow.

THE Postmaster-General has made his selection out of the 300 odd applications he had received in reply to the advertisement for six medical officers for Glasgow Post-Office. Following upon the death of Dr. Dougan, who as medical officer to the Glasgow Post-Office devoted his whole time to the duties, it was deemed inadvisable to continue the system of appointing only one medical officer, owing to the growth of the department, and the wide area in which the men reside. The postal area has been arranged into six districts, and a medical officer attached to each. The gentlemen appointed are at liberty to engage in private practice. The following medical practitioners have been appointed :—Central District—D. Watson, M.B., 116, Mains Street. Western District—R. O. Adamson, M.D., 15, Grosvenor Crescent. Southern District—W. Lawson, M.D., 36, Glencairn Drive, Pollokshields. Eastern District—J. Patrick, M.B., 23 Westercraigs. Northern District—J. M'Kie, M.B., 24, Hillside Terrace, Springburn. Govan—R. Y. Anderson, M.B., Redcliffe, Bellahouston.

Retirement of Mr. Herbert Page.

AFTER thirty years of surgical work at St. Mary's Hospital, Mr. Herbert Page has ceased to be a member of the active staff, and has been appointed Consulting Surgeon. Mr. Page was elected surgeon for out-patients on February 16th, 1876, and he held this office ten years. From May, 1886, to May, 1906, he had been surgeon for in-patients. From 1876 to 1881 he was lecturer on operative surgery in the Medical School. In 1882 he was appointed a colleague of Mr. Norton in the lectureship on Systematic Surgery. On Mr. Norton's resignation in 1888, Mr. Page was associated with Mr. Owen, and in 1897 with Mr. Pepper, in this duty. In 1900, after eighteen years as lecturer in surgery, he was appointed lecturer in clinical surgery. For two years (1888-1890) Mr. Page was Dean of the Medical School, and from 1892 to 1906 has been its Honorary Librarian. Some excellent samples of his teaching have been preserved for us in the small volume of Clinical Lectures which Mr. Page published in 1897, dedicated "To my past House-Surgeons," and entitled "Clinical Papers on Surgical Subjects." Mr. Page's long experience as Surgeon to the London and North-Western and the Great Western Railways has made him an acknowledged authority on the subject of the symptoms directly or indirectly produced by injuries caused by railway collisions, and he was much in request as a witness in "railway cases." It may be mentioned that at the expiration of his term of office, Mr. Page's generous interest in the future welfare of the Hospital has manifested itself in a donation of a hundred guineas, which is, by his request, to be devoted to the cost of the equipment of the new operating theatre for general surgery in the Clarence Wing.

Death from Hæmophilia.

An inquest was held by Mr. Coroner Hoyle at the Newcastle Infirmary, on August 6th, touching the death of John Wilson, aged three years, who died in the institution. Bertha Wilson, of 38, Franklin Street, Shieldfield, identified the body as that of her son, who, she said, had been quite healthy from birth. On Monday, July 9th, the child was playing in the yard when he fell down, and knocked his head against the wall. There was a lump on his head, which did not go away, but the child never complained of any pain from it. On the following Wednesday, the child came into the house, and complained that a child, about the same age as deceased, had kicked him on the knee. On the same afternoon witness took the boy to the Infirmary, where his leg was attended to. The doctor also noticed the lump on the boy's head, and lanced and dressed it. The boy was all right after that, until midnight on the following day, when the place on the head commenced to bleed, and continued bleeding. At 6.45 a.m. on the Saturday, witness took the boy to the Infirmary again, and the cut made by the lancing was dressed. Witness was told to go back if the blood showed through the bandage, and as it did so witness took the boy back again at 2.45 in the afternoon. The doctor she saw on that occasion, however, refused to examine the deceased's head, as it had already been once dressed that day. As, however, the bleeding continued, she tried to stop it with cold water, Dutch-drops, and spider's webs, but failed. She took the boy to the Infirmary on the Sunday night, when the head was dressed, and the bleeding stopped. A few days afterwards an abscess formed, and on Wednesday last the boy was detained at the Infirmary. Witness was informed that the abscess burst on Friday night, and the child died on Saturday night.

Dr. Willon, house-surgeon, deposed to having examined the child. Witness did not know of the injury to the leg, and apart from the abscess on the head, the child was suffering from a constitutional disease, and was what is commonly known as a "bleeder." That was the reason why the bandage had not been taken off; for if the pressure had been removed the child might at once have bled to death. It was common knowledge among the doctors that the child was a "bleeder," and that was the reason the doctor referred to by the last witness had refused to touch his head. After the first abscess burst, a second formed, and that had to be opened. The child, being predisposed to the constitutional disease, subsequently died from exhaustion, as the result of the bleeding.

TheCoroner said he had no doubt that the jury would be quite satisfied with the doctor's explanation. If the bandages had been taken off in their congealed state the probability was that the child would have bled to death there and then. The jury concurred with the Coroner, and found that death was due to exhaustion, consequent upon an abscess, which was caused by an accidental fall.

Professor Behring and Tuberculosis.

Prof. von Behring read a paper on Tuesday on the results of the researches he is making with the object of discovering a remedy against tuberculosis. He announced that he had succeeded in obtaining from tubercle bacilli a preparation to which the name of tulase has been given, and which differs essentially from Koch's tuberculin. With the help of this preparation he had been able to render animals immune against infection from the virulent tubercular bacilli. He stated that it was not impossible that preventative and healing effects might subsequently be attained by means of tulase. Clinical experiments which had hitherto been made with this substance, and which had proved that it exerted a very favourable effect on scrofulous and tuberculous diseases of children, had consisted exclusively of sub-cutaneous injections.

Queen's College, Cork.—The President's Report.

The annual report of the President of the Queen's College in Cork travels somewhat beyond its usual scope, and deals at length with the causes that tend to interfere with the full development of the Arts classes. According to the President, while extreme pressure has been brought upon students not to attend the Arts classes, the objections raised to attendance upon courses of medicine and engineering have not been nearly so great. He adds that it is quite hopeless to look for any improvement in the entries for Arts courses until some radical change has been made in the conditions of the College. Dr. Windle then quotes from his own experience of the Queen's College and the Mason College in Birmingham, and points out how reconstruction and amalgamation of the two have resulted in the great and progressive University of Birmingham. In conclusion, he urges that some effort should be made to place the College on a better footing.

Birth-rate in England.

England's birth-rate for the second quarter of the present year is the lowest recorded for any parallel period since civil registration was established. According to the Registrar-General's returns issued on August 14th, the natural increase in population in England and Wales during the quarter, by excess of births over deaths, was 111,800, against 117,850, 114,389, and 113,726 in the second quarters of 1903, 1904, and 1905 respectively. The births registered during the three months past are in the proportion of 27·5 annually per thousand of the population. The mean rate in the ten preceding second quarters was 29·1. In the registration, counties with a population exceeding 100,000 persons the lowest birth-rates during the quarter were: 21·3 in Sussex, 21·5 in Cornwall, 21·7 in Hertfordshire, 22·5 in Somersetshire, and 22·7 in Devonshire. The highest rates were 31·1 in Northumberland, 31·6 in Staffs, 32·1 in the North Riding of Yorks, 33·8 in Glamorganshire, 34·8 in Durham, and 35·5 in Monmouthshire.

Deaths registered in England and Wales last quarter numbered 125,387, and were in the proportion of 14·6 annually per 1,000. This compares with an average rate of 15·9 in the parallel periods of the ten preceding years. Of the total number, 64,903 were males and 60,484 females. Babies who died ere they attained a year numbered 24,311, the rate being 102 per 1,000, as compared with an average of 119 in the ten preceding second quarters. In the large towns the infantile mortality averaged 108 per 1,000 of the births. Burnley's rate was the highest—165.

Poisoning in British Guiana.

From Georgetown, British Guiana, comes news of an attempt to poison Professor J. B. Harrison, Director of Science and Agriculture and Government Analyst, and the whole of the laboratory staff. In June, Professor Harrison was incapacitated by a mysterious illness, which recurred in spite of skilled treatment. About the same time the laboratory was more than once entered by some unknown person at night. The burglars were apparently possessed of duplicate keys. On July 5th, Professor Harrison, after drinking ice-water from the can, was seized with headache, giddiness, and nausea. Meanwhile the assistants at the laboratory, Messrs. P. V. Garraway, Christiani, and Matthews, and the messenger, developed similar alarming symptoms after drinking ice-water from the reservoir. On the Monday it occurred to Mr. Garraway that their illness might be due to poison, and an inspection of the water receptacles showed that enough "Rough on Rats" had been placed therein to poison hundreds of people. Fortunately, all the victims have nearly recovered by now. No clue to the perpetrator of the outrage has been found.

Cancer in Essex.

Dr. Thresher, the Medical Officer for Essex, in summarising the reports of the various local medical officers in the county, states that year by year the death-roll from cancer is increasing, the figure of 527 in 1900 being increased to 721 last year. At present it causes about the same number of deaths as all the following diseases put together:—Small-pox, scarlet fever, measles, diphtheria, typhoid fever, and whooping cough.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS. ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT SURGICAL LITERATURE.

Inguinal Hernia.—In discussing inguinal hernia, White (*New York Med. Journ.*, July 14th, 1906) points out that two muscles, or the two edges of muscular tissue which lie parallel, brought close together by suture, will not unite unless the edges are freshened. In a successful case of Bassini's operation, if a dissection were made exposing the external edge of the internal oblique and the inner edge of Poupart's ligament, they would most probably be found simply lying together in a transplanted position without firm union. The author realizes the difficulty of freshening the edges of Poupart's ligament, and the internal oblique. Catgut sutures may train these parts to lie close together, yet if there is no union there will be a weak spot in that part of the abdominal wall, which may account for some of the failures in Bassini's operation. The author cuts out a V-shaped piece of tissue in the external oblique, leaving a freshened surface which will unite, and form a tense muscular wall over the weak place in the abdominal parietes. S.

Hernia of the Bladder.—Kivlin (*New York Med. Journ.*, July 14th, 1906) discusses this subject and describes three cases. Case I.—Patient showed an enlargement of the hernial site in the left inguinal region. There was a fluctuating swelling, dull on percussion, pressure on which gave rise to an instant desire to urinate. The swelling disappeared after micturition. Internal ring was enlarged. Case II.—Patient felt a sharp pain in left inguinal region four years ago, while lifting a weight. Since then he wore a truss. At the operation a sac was found which had no neck. Some adherent omentum was freed, ligatured, and cut off. To the inner and lower portions of the sac was very firmly adherent what appeared to be bowel, but on closer examination proved to be bladder. This could be traced behind the pubis. There was an unusual amount of fat in the inguinal canal, and this is said to be diagnostic of the condition. Some of the sac was cut away and closed with interrupted suture. The muscle was closed by interrupted sutures and the aponeurosis with continuous catgut. No return of the hernia occurred. Case III.—Patient, æt. 64, had suffered from hydrocœle for fourteen years. One week before operation, while moving a large stove, patient felt a sharp pain in the left inguinal region. During examination, pressing the finger well down into the abdomen gave the patient a desire to urinate, which he promptly did, passing more urine than he had done at any previous time since the trouble began. He felt fairly well relieved of his trouble. At the operation an excessive amount of fat was found in the canal. The sac was opened, and the bowel which was adherent to it was liberated. There was no neck to the hernial sac, but to the inner side of it was the protruding bladder which was extra-peritoneal and entirely independent of the sac. The bladder protruded and was free for about an inch from the margin of the transversalis muscle of the left side. The sac, which could not be tied off, was closed with continuous catgut, after ligaturing the cord and removal of the testicle and cord. The hernia of the bladder was pushed back and the direct opening closed. The abdominal layers were sutured together. Patient was discharged cured in fourteen days. S.

A New Incision for Removal of the Breast.—In making his incision, Carl Beck (*Medical Record*, July 14th, 1906) utilises the fact that below the mamma there is an abundance of integumental material. He begins by giving his incision line round the breast the form of a rectangle. The interior line of the rectangle is continued on both ends to the extent of about three inches. The same is done with the lower end of the external side, while the upper exterior end is extended along the margin of the pectoralis major muscle up to its humeral insertion. The axilla itself is not touched, in order to avoid cicatrization which is apt to produce œdema brachii. After the rectangle, including the whole breast, is excised, the upper skin flap is formed and reflected. The author is in favour of the most radical procedure as advocated by Halsted. The pectoralis major and minor are removed, and the axillary contents dissected away, so that the vessels are completely isolated. The lower flap is next lifted up and reflected. If there is any tension, the lower flap is made longer by extending the incision lines on both sides. The straight shape of the flaps greatly facilitates exact coaptation. There is no tendency for the flaps to separate, with the formation of irregular cicatrization, which so often happens with the oval or elliptical incision. S.

The Exposure of the Heart for Heart Wounds.—Wilms (*Centrblt. f. Chirurgie*, July 28th, 1906) considers that the flap operation is only suitable for wounds in the anterior wall of the heart. There is great difficulty in reaching the back of the heart by the above incision. The author describes a recent experience in the case of a bullet wound. A bullet of 6 mm. calibre entered about the middle of the left ventricle anteriorly, and emerged in a corresponding situation behind. In this case, if a flap operation had been employed, the posterior aspect of the heart could only have been sutured after resection of the sternum. The author, therefore, employed a long intercostal incision. This is best situated in the fourth or fifth intercostal space. If it is considered desirable to enlarge the opening, the fourth and fifth ribs can be removed near the sternum. When the pericardium is opened a very good view of both the front and back of the heart is obtained. The operation can also be more quickly performed. The pneumothorax which supervenes is no further complication, and it is impossible to avoid it in any flap operation. In the above case, two hours after the accident, the entrance and exit wound in the heart were each closed by three sutures. The wounds in the lung, pericardium, and thoracic wall were also completely closed without drainage. Hæmorrhage was considerable, and amounted to about a litre and a quarter. The wound healed quickly by first intention. The author considers that the intercostal incision will supplant the flap operation in injuries to the heart. It considerably shortens the duration of operation, and gives a better view and access to the heart than an equally extensive rib section. S.

A New Form of Intestinal Obstruction: The Methods for Preventing a Recurrence of Volvulus of the Sigmoid Flexure.—Moschcowitz (*New York Medical Journal*, July 14th, 1906) discusses the operative treatment of volvulus of the sigmoid flexure, especially in reference to the prevention of its recurrence. Sigmoidopexy, that is, the anchoring of the sigmoid flexure to the anterior abdominal wall, by a row of catgut or silk sutures, is the method usually employed by the author. Obalinski's method of resection of the entire sigmoid flexure, with end to end anastomosis, is severe but necessary in gangrenous cases. Senn's method of reefing the meso-sigmoid endangers the blood-supply of the gut, and is often impossible to perform on account

of the thickening of the mesentery in volvulus. Roux's method of anchoring the sigmoid flexure to the anterior and lateral abdominal wall, by sutures passing through its mesentery, is a modification of sigmoidopexy but more difficult to perform with the pathological meso-sigmoid. Riedel's method of dissecting out and removing all the cicatricial bands and deposits which are usually found in the meso-sigmoideum in cases of volvulus, is a difficult and lengthy operation, and worse adhesions are liable to form. Phillippowitz's method of anastomosing the cæcum with the efferent limb of the sigmoid flexure, depends for its success on the fixation of the sigmoid flexure, and the anastomosis is unnecessary. The author describes a case to illustrate the difficulty of preventing the recurrence of symptoms, and the further strangulation of intestines. S. S., a male, æt. 41, was admitted to hospital with symptoms of complete obstruction lasting four days. Patient had hiccough, vomiting, and absolute constipation, the abdomen was enormously distended. A median incision six inches long was made in the abdominal wall. The volvulus consisted of three feet of sigmoid flexure, the gut being at least six inches in diameter. This bowel was emptied by a rectal tube. It was then stitched to the left half of the anterior abdominal wall for about two and a half inches by a number of interrupted silk sutures. The patient made a satisfactory recovery. Three weeks after the operation symptoms of obstruction again appeared, necessitating a second laparotomy. The small intestine was found greatly distended. When the distended coils were traced to the outer (left) side of the sutured sigmoid, they were found incarcerated in a pocket between it and the lateral abdominal wall. The sigmoid was therefore freed, the adhesions removed, and the intestines liberated. The patient rallied somewhat after the operation, but died two hours afterwards. S.

Joint Diseases, especially those of Children.—In a paper on this subject, F. Willard (*New York Medical Journal*, June 23rd) calls attention to the great frequency with which mistakes occur in the diagnosis of painful joints. He discusses the signs and symptoms of the commoner varieties of joint disease, and draws particular attention to the following points:—(1) Early diagnosis is the most important of all considerations. Physicians are responsible for a large majority of joint destructions, chiefly from carelessness or indifference in the examination of their patients. A child with any peculiarity of gait should be examined naked. (2) Every physician should abandon the thought that pain in a single joint in a child means rheumatism; a limp, with rigidity of the peri-articular muscles always means some form of invasion, possibly septic, probably tuberculous. (3) Abort tuberculous infection by immediate aboslute rest, and fixation of the joint. (4) Put the patient out of doors, day and night, for a long period of time. (5) Wise conservatism consists in the prompt application of all methods of relief. whether hygienic, mechanical or surgical. In children conservatism should be the rule; in adults, operative measures are much more frequently demanded. A limb that can readily be saved in a child, in the adult will demand amputation. If an operation will best accomplish a cure, such operation is true conservatism. (6) In septic cases, open early and freely.

G.

Intestinal Obstruction due to Reflex Nerve Disturbance.— Dr. C. Clubbe (*Intercolonial Med. Jour.*, May 20th) draws attention to this condition, giving the histories of several cases, in which the intestinal obstruction was due to a reflex nerve disturbance the lesion being outside the peritoneum, and the obstruction at once relieved when the irritation subsided. The author then goes on to discuss freely the various theories as to the cause of this nervous obstruction He believes that if we have reason to suspect, in any given case, that the intestinal paresis is due to a reflex nerve irritation, then, if we can find a cause, which we think is sufficient to set up reflex inhibition, all we have to do is to relieve tension by letting out pus, whether it is in the abdominal wall, or behind the peritoneum in the region of the kidney, or wherever it may be. If the inflammatory trouble has been causing nerve irritation, and so, reflexly, intestinal obstruction nothing more need be done at the time. The abdomen need not be opened, for the intestines will take care of themselves. The importance of this fact will appeal to all those who come in contact with this class of case, for what can be more disconcerting to the surgeon, or inauspicious for the patient, than a futile search from duodenum to sigmoid for an obstruction that does not exist? G.

On Convergence in Corrected Myopia.—Bourdeaux (*Soc. Franc. d'Ophthal.*, Mai, 1905) explains the vertigo, diplopia and headache so often heard of after full correction has been ordered to myopes as being due to the altered relations between convergence and accommodation. Before correction a myope has to exercise more or less convergence when looking at something at his far point. When he adopts glasses there is still a tendency for the convergence to be in excess of the accommodation, so that if he has binocular vision it is not acquired with ease until the new relations are established. M.

Early Detachment of the Retina in Sarcoma of the Chorioid.—J. H. Parsons (*Ophthalmic Review*, June, 1905) has made an anatomical examination of fifty cases of sarcoma of the chorioid and ciliary body, and gives the following conclusions:—Detachment of the retina occurs earlier in sarcoma than is generally gathered from our text-books. The growth, of course, lifts up the retina, but there is no true detachment over it. The true detachment occurs invariably as a shallow detachment in the lower hemisphere, having no connection with the portion of retina covering the young tumour. If there is a connection between the two detachments it is simply due to the accidental position of the tumour in the lower hemisphere. When the tumour commences above there is always an area of normally-placed retina between the tumour and the true detachment below. Total detachment usually supervenes. M.

Tubercle of the Chorioid.—G. Carpenter and S. Stephenson (*The Ophthalmoscope*, August, 1905) give a full description of such a case, which revealed some unusual features. According to the authors, tubercle of the chorioid is by no means uncommon, and forms a very trustworthy sign of acute miliary tuberculosis; out of forty-two case of acute miliary tuberculosis and tuberculous meningitis which they examined ophthalmoscopically, 50 per cent. had chorioidal tubercle In the case recorded, where there was progressive wasting, oscillating temperature, rapid pulse cyanosis, hurried respirations without adequate physical cause the diagnosis was finally settled by the detection of the tubercles in the chorioid. The unusual features of the case consisted of the presence of the tubercles in both eyes and in large numbers. Instead of there being just two or three fawn-coloured spots there were about twelve situated in the "central region" of the fundus of each eye. A second point of interest in the case was the presence of outstanding nodules of tuberculosis of the retina, which seemed quite unconnected with the chorioidal nodules. The discovery of the bacillus tuberculous in these retinal deposits set at rest some doubt the authors had as to their eal nature. M.

Note.—*A Summary will appear each week in the following sequence:*—(1) "*Recent Medical Literature.*" (2) "*Recent Surgical Literature.*" (3) "*Recent Gynæcological and Obstetrical Literature.*" (4) "*The Recent Literature of Physiology and Pathology.*"

NOTICES TO CORRESPONDENTS, &c.

☞ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to 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 proofs.

CONTRIBUTORS are kindly requested to send their communications if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

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.

M.D. (Llantrissant).—Prof. A. Bergt, acting director of the Ethnological Museum at Leipzig, is one of the best men to answer the questions you suggest.

GLASGOW STUDENT.—1. Prof. Wyndham Dunstan has written a paper on the new radio-active mineral thorianite from Ceylon. It will be found among the reports of the Royal Society. 2. The annual meeting of the American Röntgen Ray Society is, this year (Aug. 29), at Niagara Falls.

DR. G. (Brondesbury).—You can get all the information you require with regard to hotels and inns for week-end motoring trips in the "Holiday Number" time tables of the chief railways. They also give the names of houses where "week-enders" are taken.

RADIUM.—With regard to acute erythema resulting from Röntgen Ray treatment the stearate of zinc composition powder, with 10 per cent. ichthyol, seems to act as a prophylactic and prevent serious burns.

SANITAS.—1. There are endless manuals on the subject, but the largest and most comprehensive is the "Practical Guide to Public Health Acts," by T. W. Hime (Baillière, Tindall and Cox), price 15s. 2. The usual plan is to saponify the butter with alcoholic potassium hydrate and then test for boric acid in the ash as usual.

FANGO DI BATTAGLIA.

SIR,—In your issue dated August 15th I notice under the heading of "British Health Resorts" an article on Matlock Bath and more particularly on the Royal Hotel there. Your correspondent has been wrongly informed when he says that the treatment by Fango di Battaglia can at present be obtained only at Matlock Bath in this country. The same treatment is in use at Smedley's Hydro., Matlock, and has been in use there during the last three years. It is only fair to the neighbouring institution that this mis-statement should be corrected in your next issue. I am, yours truly,

GEORGE C. R. HARBINSON, M.B., B.Ch.

Smedley's Hydropathic Establishment,
Matlock.

[We have received a letter from another correspondent to the same effect. "Fango" is merely Italian for "mud," and mud-baths of one kind and another are in use at many spas in Great Britain. "Fango di Battaglia" is an extremely fine deposit of volcanic origin thrown up by the hot springs at Battaglia in Italy. It is this particular "mud" which is used at Homburg, Baden-Baden, Marienbad, and Kissingen, and is now imported for use at Matlock Bath, and our correspondent believed solely imported by them for use in this country.—ED.]

DR. H. (St. Neots).—There is no doubt about the increased frequency of chorea among Board School children, and school work, if persisted in during the early stages, both retards recovery and intensifies mental distress. Many children may appear to be cured, but a return to school work causes a recurrence of the irregular movements.

TRAVELLER.—We quite appreciate your difficulties about ascertaining the sanitary condition of a place before sending a patient. The sewage saturation of the subsoil both in Port Said and Cairo is rapidly becoming a menace to public health, but the Department of Public Health is engaged in finding a remedy. Why not try Hamman R'hira in Algeria. The environment is almost as beneficial as the baths.

THE latest patent "cure" for distemper is registered by T. A. Palfrey, of Stirling Street, Alva, Clackmannanshire. It is composed of phenacetin, ammonium chloride, gentian root, and armenian bole. The mixture is used as a capsule filling.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, AUGUST 22nd.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—10 a.m.: Diseases of the Throat, Nose, and Ear. Diseases of Children. 2 p.m.: Medical and Surgical Clinics. 2.30 p.m.: X Rays. Operations. 5 p.m.: Lecture: Practical Demonstration in Cystoscopy.

THURSDAY, AUGUST 23rd.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—2 p.m.: Medical and Surgical Clinics. 2.30 p.m.: X-Rays. Operations. Diseases of the Eye.

FRIDAY, AUGUST 24th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—2 p.m.: Diseases of the Throat, Nose, and Ear. Medical and Surgical Clinics. 2.30 p.m.: X-Rays. Operations. Diseases of the Skin.

SATURDAY, AUGUST 25th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—10 a.m.: Diseases of the Throat, Nose, and Ear. 2 p.m. Medical and Surgical Clinics. 2.30 p.m.: X-Rays. Operations.

Vacancies.

Royal Hamadryad Seamen's Hospital. — Medical Superintendent. Salary £250 per annum, together with furnished residence, firing, lights. Applications to Ivor J. Roberts, Secretary, 4, Docks Chambers, Cardiff.

Egyptian Government.—Ministry of Education.—Professor of Midwifery and Gynæcology. Salary £400 a year, with private practice. Applications to the Director, School of Medicine, Cairo, Egypt.

Egyptian Government.—Ministry of Education.—Medical Tutor and Registrar to Kasr-El-Ainy Hospital. Salary £400 a year. No private practice. Applications to the Director, School of Medicine, Cairo, Egypt.

City and County of Kingston-upon-Hull.—Appointment of Resident Medical Officer, Infectious Diseases Hospitals. Salary £200 per annum, with residence, board, and washing. Applications to E. Laverack, Town Clerk, Town Hall, Hull.

Chesterfield and North Derbyshire Hospital and Dispensary.—Senior House Surgeon. Salary £120 per annum, with board, apartments and laundress. Applications to the Secretary at the Hospital.

East London Hospital for Children and Dispensary for Women, Shadwell, E.—Medical Officer for the Casualty Department. Salary £100 per annum. Luncheon is provided at the Hospital. Applications to W. M. Wilcox, Secretary.

Fisherton Asylum, Salisbury. — Second Assistant Medical Officer. Salary £120 per annum, with board, apartments, and washing. Applications to the Medical Superintendent.

York County Hospital.—House Physician. Salary £100 per annum, with board, residence, and washing. Applications to Fredk. Neden, Secretary and Manager.

The Middlesex Hospital, W.—Second Assistant to the Director of the Bacteriological and Clinical Laboratories. Salary £100 per annum. Applications to F. Clare Melhado, Secretary-Superintendent.

County Asylum, Dorchester. — Junior Assistant Medical Officer. Salary £140 per annum, with board, lodging, &c. Applications to the Medical Superintendent.

Royal Victoria Hospital, Dover. — House Surgeon. Salary £100 a year, with board, lodging, and washing. Applications to the Hon. Secretary, Arthur B. Elwin, Esq., 2 Castle Street, Dover.

York Dispensary.—Resident Medical Officer. Salary £120 a year, with board, lodging, and attendance. Applications to W. Draper Esq., De Grey House, York.

Appointments.

HARRISON, JAMES MCKEAN, M.B., B.Ch., B.A.O., R.U.I., Medical Officer to the Workhouse by the Ledbury (Hertfordshire) Board of Guardians.

HOLLAND, EARDLEY L., M.B., B.S.Lond., F.R.C.S.Eng., Assistant Resident Medical Officer to Queen Charlotte's Lying-in Hospital, London.

LYSTER, ROBERT ARTHUR, M.B., Ch.B., B.Sc.Lond., D.P.H., B.Sc., Medical Officer of Health to the Urban District of Handsworth (Staffs.).

MORRISON, J. W. H., M.B., B.S.Durh., Certifying Surgeon under the Factory and Workshop Act for Blaydon-on-Tyne District of the county of Durham.

SELLS, H. LANCELOT, M.B., Ch.B.Edin., House Surgeon to the Hartlepools Hospital, Hartlepool.

Births.

CHURCHILL.—On Aug. 17th, at Kien-ning, Fuh-Kien, South China, the wife of H. Melville Churchill, M.R.C.S., L.R.C.P., of a son.

JACOB.—On Aug. 14th, at 26 Hindes Road, Harrow, the wife of Archibald H. Jacob, L.R.C.P. and C.S. Ireland, of a daughter.

SELIGMANN.—On Aug. 14th, at 15 York Terrace, Regent's Park, the wife of Charles G. Seligmann, M.B., of a daughter.

SHATTOCK.—On Aug. 17th, at Saville House, Sutton Court Road, Chiswick, the wife of Chas. R. Shattock, M.R.C.S., L.R.C.P., L.D.S.Eng., of a son.

Marriages.

MEREDITH—SMYTHE.—On Aug. 15th, at All Saints' Church, Maidstone, Herbert Duncan Craig, younger son of John E. Meredith, B.A., M.D., of Maidstone to Evelyn, youngest daughter of the late Algernon Sydney Smythe, of Ivythorne, Maidstone.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIII. WEDNESDAY, AUGUST 29, 1906. No. 9.

NOTES AND COMMENTS.

M.B.M.A.

IN the current issue of "First Aid" (published on the 20th of the present month) the Editor harks back nine weeks to quote the leaderettes on the M.B.M.A. question, which appeared in our columns for June 27th last, and *inter alia* remarks "We think, in common fairness to the association (St. John's Ambulance) and its loyal adherents, they should explain more fully their reasons for this charge; in other words, should give the names of the delinquents." We have pleasure in conforming to the request of our contemporary, and give the name of Mr. Vaughan Bateson, a registered medical practitioner, who affixed to his name on a pamphlet entitled "Notes on First Aid" the letters "M.B.M.A.," in addition to over a score of others, including his medical titles. The editor of the screed mentioned shows in our opinion needless bias in his remarks, and we beg to point out to him that the matter has been already fully dealt with not only by the local (Bradford) Ethical Society, but, what is more important, by the Central Ethical Committee of the B.M.A., who have considered the matter of such importance that they have specially inquired into the question and have issued a decision that these letters "M.B.M.A.," may not be used in the way they were by any member of the British Medical Association.

An Election Scene.

A remarkable scene took place at a meeting of the Cork Guardians the other day, when the question of the election of a specialist to attend for the eye, ear, and throat cases under their jurisdiction came up. It seems that it has been the practice of the Guardians to send patients requiring special attendance for ophthalmic and throat diseases to hospital, and that it was recently considered that it would be a more convenient and economical arrangement to have a specialist engaged to attend cases when necessary. As the specialist was only offered fifty guineas for the first year and sixty guineas per annum afterwards, the proposal can hardly be considered extravagant, but when the business of election to the post came before the Guardians it was found that two well-qualified gentlemen, Dr. D. P. Fitzgerald and Dr. James M. Browne were willing to undertake the necessary duties. The meeting was sharply divided into partisans of the two doctors, one side contending that they wanted a specialist, and the other that a well-educated, well-qualified man should not be left out of the running because he practised generally as well. The partisans eagerly backed up their contentions, and a very hot time ensued, all sorts of improper influences being alleged, and a considerable amount of personal abuse indulged in. An amendment was proposed to adjourn the election for six months, and this took so long to discuss that the Guardians eventually clustered round the rostrum on which the chairman was seated, and banged on it with their hands. In the end this undignified scene came to a close by the amendment being carried; we shall be interested to notice its final result.

School Touting.

WE notice in *Truth* that a doctor recently called the attention of its editor to the methods of the Ebor Educational Agency, of 10, St. Oswald's Terrace, York. This concern sent to the doctor in question a circular asking him on his daily rounds to ascertain in the ordinary course of conversation, without letting parents think that he is interested in the matter, whether they are likely to be sending their sons or daughters to school, and if so to send their names to the Agency with any particulars he could give. For every pupil placed through the doctor's instrumentality a guinea was offered, and he was assured that the Agency had many doctors in different parts of the country now acting for them. We are glad to hear that the doctor declined to have anything to do with such undignified touting, and if the Agency meant that they have a number of doctors who use their profession as a cloak for pushing the Ebor Educational Agency by the underhand methods suggested, for our own part we flatly decline to believe the statement. The Agency, if it descends to such unworthy dodges in working up business, might at least do so on its own responsibility, without seeking to involve in its degradation the members of an upright profession.

Bravo, Mr. Mead!

THERE are always a number of self-opinionated, hot-headed, irresponsible people who are inclined to attribute the worst of motives to others, and of such are the majority of anti-vaccinationists. A man has a perfect right to believe or not believe in vaccination; in a free country a man is allowed to be a fool without let or hindrance, and any man who denies the protective influence of vaccination is as much of a fool as a man who denies the pro-

tective influence of a pure water supply. A wise man may doubt whether universal compulsory vaccination is the best way of stamping out small-pox in a democratic community, and he, too, has a right to his opinion. But it is particularly obnoxious and quite uncalled for that anti-vaccinationists should perpetually be sneering at medical men, and attributing dishonesty to them. We are delighted to see that one of these gentry got a sharp rap over the knuckles the other day. He was applying to Mr. Mead for an exemption certificate, and said that two of his children "broke out in sores" a month after being vaccinated. On being asked what the doctor thought was the cause of the sores, the applicant replied, "Oh, it isn't his duty to say they were due to vaccination." Mr. Mead asked him promptly whether he meant to suggest that doctors were liars, and asked him to apply the argument to his own calling, that of an insurance agent. As the man had not made proper inquiries about the cause of the children's illness Mr. Mead said he could not regard the objection as conscientious, and therefore he declined to grant a certificate.

LEADING ARTICLES.

OPERATIONS ON THE CENTRAL NERVOUS SYSTEM.

SIR VICTOR HORSLEY naturally chose as his subject for the address in surgery at the British Medical Association meeting that branch of the art in which he has had most experience—namely, operations on the central nervous system. He began his address by recalling the facts that it is just twenty years since he showed to the Association the first three patients on whom he had operated for intracranial disease, and that on that occasion the principles he suggested as a guide in cerebral surgery were based chiefly on operations performed on the lower animals. Since 1886 surgeons have been operating on the nervous system in all parts of the world, and the present is, therefore, not an inopportune moment to try to gather from their collective experience the materials for forming a judgment on the utility and range of this department of surgery. Such operations fall, as Sir Victor Horsley pointed out, into two classes, those which are merely palliative and those which are designed actually to cure. The former are directed to relieve pressure symptoms and all the pain and misery resulting from them, and with that object not only are they justifiable but they constitute a positive obligation on practitioners in charge of cases of cerebral tumour. Optic neuritis and its resultant blindness are, unless the optic tract is specifically implicated, due to pressure and pressure alone, and by early operation they may be obviated with certainty, and the terrible headaches, the vomiting, and the other symptoms that make unbearable the life of patients with intracranial growth are equally amenable to the same measure. If cerebral surgery had nothing to point to beyond the ascertainment of these facts, it would not have been attempted in vain, and it behoves physicians never to let the possibilities of these palliative measures slip their memory, nor to wait too long before desisting from drug treatment and handing their patients over to the surgeon. When, however, surgery aims at cure or permanent relief, it is apparent that a number of questions arise, which may well tax the science of neurological diagnosis beyond its present capacity. The nature, the extent, and situation of the growth must all be known or conveniently guessed at, and the practicability of the success of an operation carefully gauged, whilst, moreover, the damage to cerebral tissue which will be inevitable, must be set against present and probable damage by disease. Sir Victor Horsley, we are glad to see, is not moved to join the "forward" school of cerebral surgeons, but entered a wise caution against unnecessary mutilation of the brain. The bulk of the address was taken up in the discussion of the details of operative procedure, beginning with the previous preparation of the patient and ending with the special treatment of individual regions of the brain, and as the outcome of the lecturer's peculiarly long and varied experience, the views expressed have a high value. Surgeons will be particularly interested to learn that Sir Victor Horsley believes that the manner in which the skull is opened is responsible to a great extent for the amount of shock produced, and that he is opposed to using vertical pressure or force; in fact, his own practice is to remove a piece of bone with the trephine, mark out the rest of the area to be removed with saw-cuts, and then cut away that area with bone-forceps by directing all traction outwards. Another practical point which may not be generally known is the ease with which Sir Victor has found capillary oozing to cease when inhalations of oxygen are given to the patient. The oozing is only troublesome when some degree of asphyxia is present, and if congestion be relieved by free stimulation with oxygen, no further measures are needed to control the bleeding. The address will be found full of interest to practitioners of all branches of the profession, for it deals with a department of surgery in which, though its results have not been as brilliant as those in other domains has yet made solid advances which at times are in danger of being overlooked.

THE CIRCULATION FROM THE PERIPHERY.

IN various ways the subject chosen by Sir James Barr for the Address in Medicine at Toronto is one of special interest to the philosophical student of medicine. The author brought to his task not only the ripe experience of a physician, but also a wide range of experimental knowledge. The importance of the capillary circulation in many diseased conditions is becoming more and more recognised. Raynaud's disease may be taken as a specific instance of local asphyxia. It has always hitherto been ascribed to vasomotor spasm, but Sir James Barr has shown that, like other allied asphyxias, it is in reality due to diminished blood-pressure in the arterioles. Similarly defective vasomotor action leads to congestion of the areas

involved, such, for example, as happens in orthostatic albuminuria, when the cause mentioned acts upon the whole splanchnic region. Another recent fillip to the study of the peripheral circulation has been given by the discovery of adrenalin, from a study of whose action upon the brain, heart and lungs, Sir James inferred the absence of vasomotor nerves. From that observation it follows that the circulation in all these organs has to be maintained by the heart alone, that is, independently of any regulating centre. Incidentally the condition is one that may profoundly affect the action of various drugs. An interesting explanation was given of the occurrence of cold feet in bed, and its proper remedy was shown to consist in elevating head and shoulders to raise the arterial and capillary pressure in the lower extremities. Sir James Barr emphasised the familiar precept that a man is as old as his arteries, and that after the age of fifty arterio-sclerosis directly or indirectly kills more people than any other disease. The whole address is characteristic of the philosophical researches undertaken by the modern physician in his pursuit of knowledge. Its suggestive value is incalculable, both as a stimulus and an example to others labouring in the same field. It affords, indeed, a fine example of the species of laborious investigation which in the hands of British observers has from time to time yielded brilliant results, and which, in earlier days, laid the scientific foundation of modern medicine in the discovery of the circulation of the blood.

NOTES ON CURRENT TOPICS.

"Truth" and Mr. Sewill's Offer.

We are thankful to note that Mr. Sewill's offer to start a guarantee fund for the collection of evidence against quackery has not passed unnoticed. The editor of *Truth*, with whom we have once at least found ourselves in conflict, is animated like ourselves with disgust for the thieving knaves who batten on the imbecility of their countrymen, and more than any other person he has been instrumental in bringing several of these rogues to justice. He confesses that he is unable always to see eye to eye with us, which is unfortunately the fact, but at the same time we note with great satisfaction that he, too, is in favour of the appointment of a Royal Commission to investigate the ways of quacks and quackery, and that he is prepared to support Mr. Sewill's suggestion. In the last number of *Truth* he tells us that almost single-handed as far as the lay press is concerned he has fought the evil of quackery, and that if a Royal Commission were appointed he fancies he has sufficient evidence to keep them employed for a month or two. Knowing that Mr. Labouchere is a fighting man, we cordially welcome his co-operation, and knowing that he is better cognisant of the ways of society pests than anyone else, we feel his support is better worth having than that of any other individual. If he will help us to get an independent inquiry which will turn the searchlight of truth into the tricks of the parasites who suck a livelihood out of the misfortunes of their fellow-creatures, we are quite prepared to sink differences on points of detail. If it were generally known that the bulk of advertising quacks are blackguards of the lowest type, who find in quackery the easiest way to a comfortable living, the public might not be so eager to believe the barefaced lies that many of our contemporaries purvey in their advertisement columns.

Dr. Freyberger and Goats' Milk.

Dr. Freyberger reminds us of the Irishman who never opened his mouth without putting his foot in it. A certain perverse fate seems to dog his footsteps, and he is hardly out of hot water with one set of persons than he is in it with another. In a recent inquest on a six months old child at Battersea he was called to give evidence, presumably because that district did not contain a practitioner who was capable of making a post-mortem on a case of "malnutrition." In his evidence Dr. Freyberger is reported to have said that "death was due to malnutrition, and that goats' milk, on which the child had been fed, was worse than skimmed milk, and did not contain sufficient fat or sugar." It would certainly take an expert pathologist who had no knowledge of medicine, hygiene, or dietetics to make so fatuous a statement, and if Dr. Freyberger is to continue frequently to be called in by Mr. Troutbeck he would do well to read an elementary text-book on the subject of milk. If he will compare the analysis of goats' milk with that of skimmed milk he will find he has made himself the laughing-stock of those who, though they have not become "expert pathologists," have at least retained the elements of practical medical knowledge.

The Corporation of Dublin and Consumptive Sanatoria.

At a special meeting of the Corporation of Dublin, held during the past week, it was decided to join with the Urban Councils and Rural District Councils of County Dublin in the erection of a sanatorium for consumptives on the chalet system, and to levy for that purpose a rate not exceeding one penny in the pound. Alderman Bergin, who proposed the resolution sanctioning the scheme, in the course of his speech read statistics bearing on the enormously high death rate from consumption in Dublin. He showed that while the death-rate for the whole of Ireland was 2·9 per thousand, the death rate for Leinster was 3·3 per thousand, and for Dublin 4·7 per thousand. He estimated that on a rate of a penny in the pound it would be possible in the first year to acquire a site to build forty chalets, and to maintain the patients therein, and in the second year to double the number of chalets. It was further pointed out that, if at any time the scheme became too expensive, or if the chalets were considered unhealthy by the sanitary authorities, the sanatorium could be got

rid of by the simple process of burning it down. The scheme of the Corporation has met with a considerable amount of adverse criticism, mainly on the ground that it is merely another device for spending the ratepayers' money, though one gentleman indeed went so far as to say that it was a move on behalf of the medical profession. We fear that if the Corporation are subject to such criticisms they have only their past actions to blame. At the same time, in the present case, and on the supposition that they will carry out the work as a business undertaking and not as philanthropic enterprise for the benefit of their employés, we consider that they have acted properly. It would be alike unwise and impossible for the general hospitals of Dublin to admit large numbers of consumptive patients, and it is equally unwise to try to effect, and impossible to effect, any reduction in the preventible mortality of tuberculosis by means which allow the infected patient to act as a centre of dissemination in the midst of his family and neighbourhood. As we have said, we think that in theory the Corporation have acted wisely, and we trust that the practical outcome of their project will be such as to confound their critics.

Progressive Advertising.

WE find we have a contemporary called *Progressive Advertising*, and that in its opinion we, on July 25th, "waxed quite hysterical on the iniquity of one of the great dailies publishing an advertisement entitled "Startling Advance in the Cure of Disease—Medical Enthusiasm." The great daily in question was the *Standard*, a fact as to which *Progressive Advertising* is discreetly silent, and on the point whether we "waxed hysterical" we may inform our contemporary that hysteria is a disease in which the patient fails to be guided by reason, whilst our paragraph contained carefully expressed, weighty reasons why this advertisement should not have been inserted. If the editor of our contemporary will re-publish this paragraph entire in his columns we would willingly submit to the judgment of his readers whether our contention was reasonable or not. But the writer knows perfectly well that advertising of this kind is improper, for later on he proceeds to say "it is unfortunate that a tighter hand is not placed on these advertisements at their "port of entry," and it is equally clearly visible that he is trying by a piece of special pleading to defend a kind of progressive advertising that is indefensible. The trick of inserting paid advertisements so leaded out as to resemble ordinary reading matter is doubtless an advance on the old methods, but it is questionable whether it is an honest and straightforward advance, and it is unquestionable that when the headlines are worded in such a way as to convey an impression that should not exist, the ordinary non-hysterical Englishman has a short and emphatic word wherewith to characterise the performance. If the editor of *Progressive Advertising* is anxious to show people how to introduce legitimate business in a legitimate way, we invite him to take his stand by us in trying to put down those quack advertisements which disgrace legitimate newspaper business.

Hope Hospital Scandal.

RECENTLY we had occasion to comment on the alleged mismanagement of the Hope Hospital of the Salford Guardians. The Board, as the result of the outcry raised by the ratepayers, resolved to hold an inquiry into their own conduct, and they invited Holland, the dismissed attendant who raised the whole question, to give evidence. This Holland refused to do except at an open, independent investigation, and we must say in fairness to the guardians, who offered him his expenses and an allowance of a guinea, that his letter in reply thanking the Board for their kind offer of a "cheap trip," was not of a tone to impress one with the genuineness of his complaints. However, the special committee met, and finding they could not get on with their business, fell to abusing each other. Fortunately, however, they did not separate till they had passed a resolution asking for a Local Government Board inquiry, and this it may be hoped will be forthcoming. There is so much gross mismanagement of poor-law infirmaries that a few inquiries, even if they cost money, will probably have a stimulating and beneficial effect.

Transplanted Kidneys.

THE triumphs of modern surgeons, thanks to Listerian methods, are to be found written chiefly in the surgery of the internal organs. Take, for instance, the kidney, which has for years past been operated upon with a freedom and familiarity that twenty or thirty years ago would have savoured of the land of fables. Perhaps one of the most daring feats of modern surgery has been the decortication of the kidney as a remedy for chronic Bright's disease. Severe as the cure may be—for it is successful in some instances—it is the only chance of curing an otherwise incurable condition. From a recent announcement, however, made at the Toronto meeting of the British Medical Association, it appears that decortication is by no means the last word in kidney surgery. An American surgeon, Dr. Carroll, formerly of Chicago, and now of the Rockefeller University of New York, exhibited two cats and two dogs in whose bodies were transplanted kidneys. He stated that in each case the kidneys appeared to be performing their functions successfully. One dog had survived the operation for seventeen days and a cat for two months. It is obvious that these experiments open up a new field of surgery. Ever since the days of John Hunter, who successfully transplanted the spur of a cock into the comb of another cock, the subject of transplantation has possessed a peculiar fascination for surgeons. That the perfection of modern surgical methods immensely increases the possibilities of the process is shown by Dr. Carroll's interesting investigation.

What is the Proper Food for Babies?

"Improper diet" is admittedly a common cause of many more or less fleeting and some of the serious ailments of childhood. It is quite another matter, however, when the medical attendant is asked to say what constitutes right and proper food for an infant. At the same time the science of infant feeding is beginning to be more perfectly understood nowadays, and the average medical practitioner should have little difficulty in keeping himself abreast of advances in the subject. At any rate, it is an easy task to say what is not proper food for children of tender age. The secretary of the recently-founded London day nurseries stated the other day that porter and pickles, sausages, currant cake and plums were commonly given to infants. Upon remonstrating with one mother for giving bloaters to her baby, the indignant relative retorted that she (the secretary) knew nothing about it, and whereas the other was not even married she herself had "buried five." The professional moral to be drawn is that medical men should conduct a collective investigation into infant feeding and establish definite rules. The subject should be systematically taught to medical students. At present the helpless mother affords an easy prey to patent foods of all kinds and obnoxious feeding bottles, just as she is to a hundred and one soothing syrups, teething powders, and other more or less poisonous proprietary medicines

Sir Victor Horsley and Alcohol.

Sir Victor Horsley's speech at the luncheon given by the Dominion Temperance Association to the members attending the British Medical Association meeting at Toronto has "caught on" a good deal, to judge by the attitude of the press in this country. In paper after paper we have read leaders and articles on the subject, and needless to say they are as diverse in their comments as they are in their political complexions. The length to which Sir Victor Horsley went—he is reported to have said that the value of alcohol as a drug was *nil*—is further than most medical men would be prepared to go, and indeed it is not arguable at all that alcohol is a drug with specific properties of which the judicious physician can avail himself with advantage in certain emergencies. That alcohol as a remedy was ridiculously over-used by the older generations of physicians is as true as that blood-letting and leeching were ridiculously over-used, and we would go as far as to say that alcohol in a general way has probably done as much harm as good. On the other hand, it is—on the same analogy—beyond the reach of argument that alcohol, blood-letting, and leeching have their appropriate uses and convenient applications; and they should be appraised at their proper worth, no more and no less, by medical men and the public. It is highly satisfactory to learn that the expenditure on alcohol at the Edinburgh Royal Infirmary has fallen in twenty years from 13s. 6½d. per patient to 3s. 4½d., and that the expenditure on milk has proportionately risen; for ourselves, we should think that 3s. a year per patient would be quite a fair estimate for the alcohol needed in the usual way. It is hardly possible to believe that even so warm a temperance advocate as Sir Victor Horsley can have denied any value to alcohol.

Cowboy and Eye-Specialist.

What can be done by an energetic chief constable in the way of getting quacks convicted was shown on August 23rd by the officer holding that post at Barnsley. A certain ex-cowboy, Noel Cody by name, found that a far better time could be obtained by "curing" cataracts in Yorkshire than by rounding up stock on the Texas plains. He gave lectures and music-hall performances, and announced he was an eye-specialist who could cure cases which no doctor could touch. Needless to say, he abused the medical profession; that is always part of the game. Certain patients resorted to his rooms where he put drops in their eyes and licked out cataracts with his tongue. At this game he netted over £20 a week by his own confession. Luckily the chief constable of Barnsley was a man of action; he collected his evidence, arrested his cowboy, and got him six months for obtaining money on false pretences. As members of the British public, we may congratulate ourselves that the case was not tried before Mr. Justice Grantham.

PERSONAL.

Amongst those who received the honorary D.Sc. at Leeds last Saturday were Professor Ray Lankester, Professor Alfred Grandidier, of Paris, Professor Paul Pelseneer, of Ghent, Professor Heinrich Rubens, of Berlin, Sir W. H. Parkin, Dr. Heinrich Caro, of Mannheim, Professor Albin Hallen, of Paris, Professor C. Liebermann, of Berlin, and Dr. C. A. Von Martius, of Berlin.

The body of a gentleman believed to be Dr. John McCallum Stewart, of Smithston Asylum, Greenock, was found on the railway line near Carlisle on July 31st. He had apparently opened the outer door of the carriage in mistake for the door leading into the corridor. He succumbed later. He was travelling from Greenock to London.

On July 27th Dr. J. Stuart Nairne, honorary consulting surgeon at the Samaritan Hospital, was presented with a Japanese carved consulting chair and a cheque for £300, together with a silver tray for Mrs. Nairne.

Her Royal Highness Princess Henry of Battenberg presided at a meeting of the General Committee of the James Memorial Hospital at East Cowes, of which she is President.

The University of St. Petersburg has conferred its honorary membership on Sir Frederick Treves, Lord Rector of Aberdeen.

Dr. Wallace Pomeroy becomes District Surgeon of Brandfort, Orange River Colony, in succession to Dr. Last, who has resigned.

Mr. H. C. Pretty, M.R.C.S., L.R.C.P., is head of the batting averages and second in the bowling averages for the Northamptonshire County eleven this year.

A CLINICAL LECTURE
ON
SOME POINTS IN REGARD TO EMPYEMATA.

By HERBERT FRENCH, M.A., M.D.Oxon., M.R.C.P. Lond.,

Assistant Physician to, and Demonstrator of Morbid Anatomy at, Guy's Hospital.

GENTLEMEN,—I thought that to-day we would consider some points about empyemata. First, as to the causes of empyemata. An organism is the ultimate cause, and probably the most common organism in these cases is the pneumococcus. It is, however, necessary to diagnose the empyema before the special organism at work can be determined; and, therefore, I think a bacteriological classification of empyemata is not the best for clinical purposes. I think you will find it useful to divide the causes of empyemata into two main groups, namely:—

(1) The *common*,

(2) The *possible*, causes.

The *common* causes are not many. First and foremost, we have pneumococcal affections of the lung—lobar *pneumonia* and *bronchopneumonia*. Secondly, and rather less commonly, we have *phthisis*. Thirdly, especially in children, we have empyemata which develop with no apparent cause, unless it be *neglect* and dirtiness. Such empyemata are sometimes called primary, but it is not at all unlikely that there has been some unrecognised bronchopneumonia in many of these cases, whilst in others the micro-organism may have found ingress from spots or impetigo on the skin. These are all the common causes.

There are many ways in which you can divide up the *possible* causes, but certainly we put under the first heading *secondary to trouble in the lung*. Amongst these causes we have to repeat lobar-pneumonia, bronchopneumonia and phthisis, and to add such conditions as bronchiectasis, or conditions in which there is gangrene of the lung or septic bronchopneumonia, or growth in the lung, or obstructed bronchus, from any cause, with putrefaction of the secretion which accumulates behind the obstruction

We will take another heading. An empyema may be *secondary to some sepsis, near to, but outside, the pleura*, as, for example, to sub-diaphragmatic abscess from any cause, such as a leaking gastric ulcer or growth. An empyema might in a similar way be secondary to an appendicular abscess, or to pyosalpinx, or to perinephric abscess; it might be secondary to pus in connection with the vertebræ or spinal caries; it might be secondary to a suppurating focus in the mediastinum, due to some such cause as an ulcerating epithelioma of the œsophagus; it might be secondary to an abscess in connection with a rib, tuberculous or otherwise.

In addition to being secondary to actual collections of pus near the pleural cavity, an empyema may result from a *metastatic condition in which infective material may be conveyed to the pleura from a distance through the blood-stream*, as in cases of osteomyelitis, or uterine sepsis after labour, or a simple effusion may become septic by infection with organisms absorbed from a boil, a whitlow, from pyorrhœa alveolaris, or from any other focus in some part away from the lung altogether.

(a) Lecture delivered at Guy's Hospital on Wednesday, June 6th.

There is another group of cases in which people who are ill with something entirely different may develop an empyema. For instance, a patient suffering from Bright's disease, or other *constitutional disorder*, may spontaneously develop an empyema, without there being any obvious source for the pleural infection.

When you have a case of empyema, always try to make up your mind what the cause is in that case. As evidence of the importance of not being content with merely diagnosing empyema, without also satisfying yourself as to the cause of it, I want to read you notes of a case that is now in Clinical. A woman, æt. 45, had been taken ill fourteen days before admission, with vomiting and diarrhœa. Four days later there was acute pain in the right side of the chest, and she was seen by two careful doctors, who thought that the signs indicated an empyema. They needled the chest, and found clear fluid with flakes of lymph in it. Following the needling, and over the area where it had been done, there developed a reddened, raised patch, which looked as if an abscess were forming under the skin, and the patient, who did not seem to be doing well, was sent up to the hospital. On admission there was a large tender fluctuating swelling behind, over the right side of the chest, reaching from the posterior axillary line to half an inch internal to the spine, and from the tenth rib to the angle of the scapula. Over that area there was a very impaired percussion note, with bronchial breathing. The cardiac impulse was half an inch outside the left nipple line. A needle was put in, pus was found; an anæsthetic was given, a rib resected, and the part having been drained, the patient was put back to bed. We had correctly diagnosed and treated an empyema; I am afraid we felt satisfied, without having decided why the empyema had come there. For the next week the temperature was perfectly normal, and there was no evidence that anything else was the matter with the patient. But on the ninth day there was a rigor, and the temperature went up, and a series of rigors, with high temperature, occurred on the five following days. The wound seemed to be draining perfectly well, and one thought of infective endocarditis or pyæmia. We could not find any cause for the rigors and the pyrexia. On the twelfth day after admission it was noticed by my clinical assistant, Mr. Davies, that the liver was one and a half inches lower than it had been. There were no signs of heart failure, so that the enlargement could not be due to passive engorgement. It looked as if the liver had been pushed down, and that there was pus underneath the diaphragm. Mr. R. P. Rowlands performed a second operation; he found the diaphragm pushed right up, so as almost to bulge into the opening made in draining the empyema. He incised the diaphragm, and found pus beneath it; on putting his fingers into the sub-diaphragmatic abscess cavity, he found these two renal calculi free in the pus. The case was primarily a calculus in

the kidney which had caused this perinephric subdiaphragmatic abscess which, in turn, had infected the pleura and brought on an empyema. It is noteworthy that there had been no definite symptoms of renal calculus in this case. It was found on careful subsequent inquiry that there had been an obscure attack of pain in the right side of the abdomen two years previously, without any urinary changes. There was no pus, nor any blood, in the urine when the patient was admitted for her empyema. One point, therefore, which you can learn from this case is that renal calculus may exist, and cause even a suppurative lesion, with practically no symptoms at all; but the main point that I wish you to remember is that the fact of there being an empyema does not finish your diagnosis; you must form your opinion as to the cause of the empyema before being satisfied.

I have an autopsy abstract of another case which illustrates that same point. The patient was a man, æt. 42, who, three weeks before admission, had a slight attack of pain which was referred to his right iliac fossa. He did not get well, being troubled with pain in the right side of the chest. He became dyspnœic, and had all the signs of a right-sided pleuritic effusion. He was tapped, and fifteen ounces of blood-stained serous fluid were drawn off a week before he died. His pain in the right side of the abdomen was thought to have been a referred one, from the inflamed pleura, though appendicitis was discussed. He got worse, and was explored again, but no pus was found. The case was diagnosed as one of very acute pleurisy, the acuteness accounting for the blood-stained effusion. He died, and at the autopsy we found that this man had had an appendicitis. The appendix was only slightly inflamed. Behind the ascending colon there was a kind of narrow rivulet of dirty lymph, and this rivulet opened into a sort of superficial lake of pus over the surface of the liver. There was no hole in the diaphragm, but above the diaphragm there were a good many ounces of clear serous effusion which compressed the lower lobe of the lung on the left side, and an older adhesion which shut the pleural cavity into two, and thus prevented a great collection of pus above the septum from getting down on to the diaphragm. In the same pleural cavity we had both a serous effusion and an empyema, separated from one another by inflammatory adhesions, but both due to infection of the pleura by pus below the diaphragm. Therefore, again I say, if you have a case of empyema, try to make up your mind what the cause of that empyema is.

You will remember that it is extremely rare for an infected pleura to give rise to peritonitis, whereas it is not at all uncommon for an infected peritoneum to give rise to pleurisy and empyema. It seems that this depends upon the fact that the lymphatic stream through the pores of the diaphragm is entirely from below upwards, and not from above downwards.

The next series of points that I want to touch upon are the physical signs that may arise from empyemata. These may be put into two main groups, namely :—

(1) Those *where the pus is* in its usual position, namely, *at the base of the lung.*

(2) Those *when the pus* is in some abnormal position, *not* at the base of the lung.

Remember that pulmonary physical signs depend entirely upon the physical condition of the lung. In the case of empyemata, the physical signs which you find are not due to the presence of pus, but to the fact that the pus expels the air from the surface parts of the lung.

The three main groups of *ordinary* physical signs that you get from empyemata differ according as there is (1) a small quantity of pus; (2) a medium quantity of pus; or (3) a great deal of pus. The physical signs when there is a great deal of pus in the usual position in a pleural cavity are easy to understand. The lung becomes completely airless from compression, so that there will be many negative signs; the affected side of the chest will not move properly with respiration; there will be no tactile vocal fremitus, no resonance, no entry, and therefore no vesicular murmur, no bronchial breathing, no rhonchi, no râles, no voice sounds; there will be two very important positive signs, namely —the intercostal spaces will be filled up, and the cardiac impulse will be displaced away from the affected lung.

When there is a good deal of pus, but not enough to express all the air from the upper part of the lung, we shall have similar physical signs, less in degree, but in addition we shall have skodaic resonance over the upper lobe, and, close to the upper border of the pus, here (shown on blackboard) we shall have compression of the alveoli, but not of the bronchial tubes, and may, therefore, expect a narrow strip of bronchial breathing with bronchophony, pectoriloquy, and very little ægophony.

It is in cases where, though the pus is at the base of the lung, its amount is *small*, that the chief difficulty as regards the interpretation of the physical signs arises. This is particularly so in children, because in children, I do not know why it is—the pus usually forms into a thin layer upon the surface of the lung, and, therefore, causes very little compression of the lung and the chest wall is so soft that an empyema can bulge the chest wall out as easily as it can push the lung in. The result is that there may be no compression even of the alveoli, and, therefore, notwithstanding the presence of pus, the physical signs may be the same as those given by the healthy lung. I must repeat what I have said before—the *presence of pus does not* by itself give rise to typical physical signs; if there are abnormal physical signs in these cases, it is because the physical condition of the lung is altered by compression by the pus. *If the pus does not compress air out of the lung*, there will be the usual resonance and the usual vesicular murmur. If the pus is in sufficient quantity to express the air from the alveoli, without compressing the bronchial tubes there will be physical signs exactly like those of confluent bronchopneumonia. At the affected base there will be somewhat impaired resonance, and on auscultation bronchial breathing will be heard, with bronchophony, pectoriloquy, and probably crackling râles. The pus will be insufficient to cause those two important positive physical signs of empyema, viz., displacement of the heart, and filling up of the intercostal spaces. Such cases are termed, sometimes, *latent* empyemata.

I have notes of a case of latent empyema at the base of the lung, which gave rise to the above physical signs. The patient was a child, æt. 7 months, who was suffering from dyspnœa, drowsiness, and loss of appetite. The child had well-marked rickets, pulse 164, temperature 103, respirations 50. The two sides of the chest were symmetrical, and resonant everywhere except over the right lower lobe, where it was impaired but not *dull*. Beware of calling notes dull; most notes described as dull are notes of impaired resonance. When you have any resonance left, there must be some air in the

lung. Over the area of impaired resonance there were bronchial breathing, fine râles and pectoriloquy, Over the rest of the lung there was puerile breathing without any râles at all. The dyspnœa became so great in that case, and the signs in the lung were so few, that tracheotomy was done, in the belief that there was diphtheritic obstruction to the larynx. This gave some relief, but the child died next day. From the right side of the chest four ounces of fluid pus were measured, in addition to some thick lymph; on the left side there were two ounces of pus and very thick lymph over the lung. The right lower lobe was compressed, with some bronchopneumonia, and the left side all over had patches of bronchopneumonia, none of which came to the surface. There you have a case in which pus was present in both sides of the chest, with bronchopneumonia, but the compression by the pus was so slight that there was not enough absence of air in the lung to give definite physical signs, and therefore a diagnosis of empyema was very difficult to make. Very often the only way in which you can diagnose a case of empyema in children is by exploring the chest with a hollow needle, and even then it is not always possible to discover the pus. It is important to try in every suspicious case, because the child is almost certain to die if the pus be not let out.

Is there any danger in needling the chest? "It hurts when the needle goes through the skin," is an objection to needling the chest, but by giving chloroform or ether you get over that. In most cases the patient is already so ill that the pain produced by the needle is but little felt. It is seldom that any anæsthetic, either local or general, is required. As to the production of a pneumothorax, it is very difficult to bring about that condition in a healthy man. If you tried to produce a pneumothorax in your next-door neighbour, you would have to take away a portion of the rib, and put your finger into the hole made, and between the two layers of pleura for nearly an inch all round the opening where the rib was taken away, before you could overcome the capillary cohesion of the two layers of pleura. It is not at all difficult to produce a pneumothorax in the chest if you have got the layers of pleura already separated, but if you have got the two layers well in contact, putting a needle through the pleura would not produce a pneumothorax.

So much for the physical signs when the empyema is at the base of the lung. Let us now consider some anomalous cases, in which the pus is elsewhere than at the base, being shut off by adhesions, and prevented from reaching the lowest part of the pleural cavity. It is clear that such empyemata may be almost anywhere; but there are four main headings under which they may be grouped, namely:—

(1) When the pus is loculated between the diaphragm and the lower lobe.

(2) When the pus is loculated between the lobes.

(3) When the pus is held up by a septum so as to be apical, or nearly apical, in position.

(4) When the pus is anterior to the lung, compressing the lung backwards.

These illustrations upon the blackboard (drawn by lecturer) will show you what I mean. I can also illustrate some of these conditions by cases, and by specimens from our museum.

I have here the notes of the case of a man, æt. 28, who came in complaining of being generally ill, and having profuse and foul expectoration at intervals. He had been hale and hearty up to nine months before admission. He was taken suddenly ill, with acute pain in the right side of his chest, and conveyed to Bow Infirmary, where he was laid up for seven weeks. The diagnosis was quite obscure. He improved, but he did not recover properly, and was brought here. His breath became very offensive and he began to expectorate foul matter in large quantities. During the nine months of his illness he lost 3st. in weight. He had got practically no abnormal physical signs at all. The chest was barrel-shaped and symmetrical, and moved well on respiration, with vocal fremitus on both sides, and fair vesicular murmur without râles. There was a case, then, of a man who had got something wrong with his chest, and who was bringing up a large quantity of foul sputum, and who was apparently suffering from some such affection as bronchiectasis, or a hidden empyema, or a sub-diapragmatic abscess, or gangrene of the lung. There were no physical signs to assist the diagnosis; gangrene of the lung was excluded by the absence of elastic fibres from the sputum. The temperature came down gradually, and a diagnosis of hidden empyema which had ruptured through the lung was made. A empyema may be hidden in two places. Supposing that you have the diaphragm adherent to the edges of the lower lobe of the lung, so that anything between the diaphragm and the pleura could not go forwards or backwards, it would then have to enlarge upwards, and there would be a collection of pus between the diaphragm and lung, giving rise to a supra-diaphragmatic abscess. There might be no abnormal physical signs at all. Then again, an empyema may be hidden between the two lobes of the lung; pus may collect there and compress a certain amount of the lung all round, but if it does not render the lung airless at the surface, there will be no abnormal physical signs. This man had got an empyema between the lobes which had ruptured into the lung, and given rise to the foulness of the sputum which he brought up.

I have here a specimen illustrating such a condition as that. There (shown by lecturer) is the empyema, and they have had to cut the lung in all directions to expose the inter-lobar septum and show where the empyema is. There have been three cases in the hospital during the last two years, with the physical signs exactly the same as in the case of that man.

This (other) specimen shows you a complete septum separating the pleural cavity into two entire halves, an upper and a lower pleural cavity, with pus in the one above, and none in the one below.

I will read you notes of an actual case of this. The patient was a boy, æt. 4, who had measles nine months before admission, and bronchitis ever since having that disease. Eventually his face began to swell, he brought up blood-stained sputum, was feverish, and lost appetite. On admission the pulse was 120, the temperature 99·2, respiration 60. The patient's face was swollen, he had marked cyanosis of the lips, and pains over the intercostal spaces. The left lung was dull from the apex to the base, with bronchial breathing, crackling râles, bronchophony, and pectoriloquy all over. The right upper and middle lobes were resonant, the right lower lobe was dull, with bronchial breathing and crackling râles all over it. The liver could be felt as low as the umbilicus. Both sides of the chest were explored in three places, but no pus was found. The child died the same night. An old pleurisy was found, and this formed a septum shutting off the lower part of the left pleural cavity from the upper,

which contained five ounces of pus. The right and left lower lobes were without any empyema at all, but were almost airless from confluent bronchopneumonia. Here, then, was an example of apical empyema, and it was a remarkably difficult condition to diagnose, but it is one that occurs from time to time. The mere fact of not finding pus with a needle is no proof that pus is not present.

I have got all kinds of specimens here to show you. Here is a lung, and you can see the upper and lower lobes, the posterior and anterior surfaces, and a septum between the two. Here we have a large cavity with a pyogenic membrane lining it in the *front* part of the lung. In this specimen the empyema is not behind, but in front, shut off by a vertical septum. What would be the physical signs in this case? As I have already said, physical signs are not due to pus being present, but to the pus making the lung contain no air. In this patient there was enough pus in the front of the chest to compress the lower lobe backwards, and make it as airless as if the pus had been behind compressing the lower lobe forwards and upwards. These diagrams (drawn on blackboard) will show you what I mean. The physical signs with pus here (shown) would be identical with the physical signs with pus there (shown). Therefore, if we percussed that patient, there would be complete dulness behind, just as much as if the pus were behind instead of in front. In that case there would be diagnosed quite certainly pus at the base, and a needle would be put in and no pus found. Why not? Because the needle would have to pass through skin, and muscles, and between the ribs, the parietal and visceral pleura, and then these two inches or more of compressed lower lobe (indicated on blackboard) before the needle entered the abscess cavity. You can miss the pus unless you put your needle in far enough—a very important thing to remember. It is remarkably difficult to discover pus with a needle in many cases. If you keep in mind the pictures of empyemata I have drawn for you, you will no longer be surprised at this, I think. Again, you will sometimes put a needle into the same hole, draw off clear fluid one time, and pus another time, within a few minutes of one another. The explanation is that there are loculi, and there has been a little difference in the direction in which the needle has been pointed in the two explorations; a serous loculus was first tapped, whilst the second time the end of the needle had entered a purulent loculus. Then again, if you have only a little pus in the chest you may go right through the pus, and unless you preserve a vacuum in the barrel of your syringe whilst you are drawing your needle out, you will get no pus. I have seen pus missed also by going in slowly. You require to put your needle in with a jerk. If you put your needle slowly into a pleural cavity, you may simply cause the pleura to bulge forward in front of the needle as a sort of cap to it, without its actually entering the empyema cavity at all.

There is one last point, and it is a thing to beware of. In dressing an empyema, do not let the drainage tube slip inside the pleural cavity. That may happen. I know a patient whose empyema did not seem to be healing up properly, and a second operation was done, and this time the tube which had been used at the first operation was removed from the pleural cavity.

I do not profess to have dealt in any way completely with the question of empyemata. The treatment is, of course, to let the pus out as soon as it is diagnosed. Diagnosis is the main thing. If you learn nothing else from our talk to-day, I would ask you to carry away in your mind at least two lasting impressions. The first is, that in addition to diagnosing empyema it is essential to try and make up your mind as to its cause. The second is that, whilst many cases have the most typical physical signs, there are very good reasons why, in other cases, the physical signs may not be at all those which you might at first think are essential to empyema.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this Journal. The lecture for next week's number will be by G. Norman Meachen, M.D., B.S.Lond., M.R.C.P. Lond. and Edin., on "The Diagnosis and Treatment of Ringworm."*

ORIGINAL PAPERS.

THE PROGNOSIS OF PULMONARY TUBERCULOSIS.*

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The subject I have chosen for this short paper is one which has been so much discussed by those more capable of forming opinions than I am, that you may consider it presumption on my part to do more than formulate their opinions, or at most to draw deductions from compilation of statistical results. I, however, do not intend to do this, but as I have possibly seen more pulmonary tuberculosis than any other serious disease, I am venturing to give you a few of the impressions I have formed and some of the various points I take into consideration in prognosing the future of a phthisical patient. Some of these have undoubtedly been impressed upon my mind by previous reading and confirmed by experience, while others may be erroneous and due to forming conclusions from peculiar groups of cases chance occasionally throws in one's way.

In the first place I will say that I have formed the opinion that it is unwise for a patient who has definitely had pulmonary tuberculosis to ever consider himself a sound man. Once a consumptive, always a consumptive. It is, I think, a very rare thing for a patient who has physical signs of lung tuberculosis and the presence of tubercle bacilli in his sputum to get well and remain perfectly well for many years while attending to his former occupation. A patient under sanatorium treatment may lose all his symptoms and the disease may remain quiescent for a long period, but sooner or later, more especially if he tends to drift into former habits, a relapse occurs which eventually may prove fatal. Within the last few months I have had five patients of this kind. All of them have broken down after having had no active physical signs or symptoms, not even a cough for more than a year—one for nearly four years. Three of these have got practically well again, one is improving to some extent, while the fifth is rapidly getting worse. I know, of course, that a large percentage of hospital *post mortems* show healed evidence of tuberculous mischief at an apex, but nearly all of these were not diagnosed, and a large number would have been undiagnosable due allowance being given for the shrinkage during

(*) Read at a meeting of the Bristol Medico-Chirurgical Society on February 14th, 1906.

the contraction in healing. It is certainly rare to find evidence of healed mischief beyond this such as would have been easily diagnosed, as, for instance, that which would have given infra-clavicular signs.

Having made a diagnosis, one of the most important points in influencing the prognosis is, I think, the appearance of the patient and the configuration of the chest. Anyone, by inhaling a sufficiently large dose of bacilli, may generate the disease, and I suppose the major portion of sanatorium patients are not of a typical phthisical appearance.

Persons, however, of the old tubercular and scrofulous types—especially the former, those with a lively temperament and long, narrow chests—unless they are most carefully looked after, do somehow or other develop consumption. In these the prognosis is certainly very bad. There seems, as a rule, no way of stopping the disease, and life is prolonged at the most only for a year or so. In these cases the constitution is generally hereditary, and if I examined a patient of this type and found only slight but definite indications of active tubercular mischief, I should tell his friends that in spite of treatment the patient would probably gradually lose ground and would never be fit again to resume his previous duties.

On the other hand, in a patient with a well-developed chest and prominent infra-clavicular regions, who had a good family history and who possibly had developed a tubercular patch on one of his lungs after extra hard or unhealthy work, I should be inclined, if there were no signs of great activity, to give the best of prognoses—viz., that with suitable treatment he would lose most, if not all, of his symptoms, and with care would probably live many years, and during that time would be capable of doing a good deal of useful work.

Of early symptoms two of the most suggestive of the further course of the disease are hæmoptysis and dyspepsia. In my experience hæmorrhage in the early stages generally indicates a chronic form. Very often, of course, no physical signs indicating phthisis can be found at first, but when they do assert themselves they seem to be of the fibroid type, and the disease tends to run a prolonged course with intervals of good health.

Dyspepsia, on the other hand, is a bad sign. Hygienic treatment may in some cases successfully combat this, but many of the cases cannot be checked, and persistent early indigestion, especially if attended by vomiting. is often the precursor of a progressive fatal illness.

A high temperature at one examination I do not consider of much importance as a rule. The exception is possibly a high temperature—say, 104°—in a patient who does not appreciate the fact, and only feels to be a " bit off colour." This is somewhat akin to the worst forms of typhoid and pneumonia. I have two recent cases in mind which may serve as examples. A doctor's daughter was going away from home to a boarding-school, and was dressed ready to go when I chanced to look in. Her mother asked me to see her before she went, as she was not feeling very well. I found her temperature to be 104°, and her sputum on examination showed tubercle bacilli. She only lived six months. A young fellow came to consult me for general malaise. He had a temperature over 103°, but no physical signs in his lungs. Bacilli were found in his sputum. A trained nurse he was living with at the time poo h poohed the idea of phthisis, and suggested his doctor was wrong. In spite of treatment, however, he has steadily lost health since, physical signs in both lungs have developed, and he is now in a precarious condition. The value of a regular temperature chart in treatment is too well known to need comment, and when under treatment an evening temperature two or more degrees above normal persists for a month the outlook is bad. I have certainly seen exceptions to this, but they are rare and may perhaps be said to prove the rule.

From the point of view of prognosis, the pulse, to my mind, is of more importance than the temperature. The first case of phthisis I saw in private practice was that of a young man with a pulse of 80 and a temperature over 100°. That was five years ago, and he is still alive and at work, and although he occasionally has remissions he is well enough to contemplate marriage (against my advice).

On the other hand, cases I have seen with a pulse more rapid than could be accounted for by the temperature, have almost invariably rapidly lost ground.

Of the commoner complications I should like to refer to the influence of laryngeal tuberculosis on the prognosis. From cases I have seen I should divide these cases into at least three varieties: (1) Ulceration of the cords alone, (2) swelling and ulceration of parts above the cord especially affecting the mucous membrane between the arytenoids, the ary-epiglottidean folds, and more rarely the epiglottis, and (3) general ulceration in the late stages of phthisis in which the trachea is often extensively involved with the other portions.

Ulceration of the cord alone does not appear to influence the prognosis. It sometimes occurs at the earliest stages, and I have certainly seen some cases get well.

Perhaps the commonest variety is swelling and ulceration in the outer arytenoid region. This is apt to spread and cause a good deal of huskiness in the voice, a certain amount of pain from involvement of the cartilages, and often dysphagia.

Nothing, as far as I know, can do much good for these, and the interesting point is that the lung physical signs are often masked. In Mr. Lake's book on " Laryngeal Phthisis," on the front page, is a drawing of a specimen I mounted of extensive laryngeal and tracheal ulceration. I remember perfectly well that a few days before this man died we could only find slight traces of disease in the lungs, but at the *post mortem* examination both were riddled with cavities. I have a similar case at the present time of a man dying with phthisis with a throat of this kind. Over six months ago his sputum was swarming with bacilli, and since then two doctors have told him his chest was intact. He is developing a few physical signs now, but I feel certain there is much more mischief than these indicate. Why this is so is probably due to small inlet of air into the lungs, and with a throat of this kind I generally conclude that the lungs are much worse than examination of them indicates, and that the prognosis is bad.

Before ending these disjointed remarks, I should like to briefly consider how the effect of treatment should influence the prognosis.

If after a few weeks' treatment there seems to be no improvement, but rather deterioration, a change of sanatorium is indicated; and if the result is similar, then after two or three different localities have been tried, it is perhaps better to allow the patient to please himself how he ekes out the last little bit of his wretched existence.

The majority, however, I suppose, improve for a time under hygienic treatment anywhere. In some this improvement is only transient, and a maximum is reached in a few weeks, with a steady decline in health afterwards. These patients are very unsatisfactory, and usually in them the prognosis is almost as bad as in those who do not improve at all. Another very annoying group of cases are those who are sent out of sanatoria "*cured*" or "*much improved*," who begin to lose ground directly they come home and resume their necessary duties, although generally under more improved conditions than before. This unfortunately includes a large portion of patients, and I have repeatedly had cases under my charge who have been sent home from sanatoria as well who succumbed in a few months to the disease. The only real test of satisfactory improvement is for patients to be able to live at their homes and to earn a livelihood for months without breaking down.

These, gentlemen, are a few of the points I consider in foretelling the future of a consumptive. They are, I know, far from complete, and purposely so. I have simply given a few ideas first hand, and have intentionally omitted the influence of concurrent diseases, and the effect on the prognosis of the amount of the tuberculous mischief and its position in the lungs. This is beyond the scope of the paper. The disease is a very deceptive one. Many accidents may happen, and it is unwise to be too definite. To make my remarks quite clear, I will end by enumerating the various points mentioned:—

1. A phthisical patient should never consider himself sound, at least not for some years, even after loss of all symptoms.

2. The appearance of the patient, the shape of his chest, and his family history are of the greatest importance in prognosis.

3. Of early symptoms hæmoptysis by itself is rather a good sign, while dyspepsia is a bad one.

4. Fever at one examination as a rule does not help the prognosis, but persistent evening temperature for a month is bad.

5. A rapid pulse is one of the worst of omens

6. Of throat complications, ulceration of th cords alone does not indicate much; swelling in the larynx is much more serious, and the physical signs in the lungs are often deceptive in these cases.

7. The effect of treatment can be gauged only by the condition of the patient several months after he has left the sanatorium and has undertaken duties he intends to perform for the rest of his life.

Addressing a jury at Clerkenwell Coroner's Court Mr. Walter Schröder said he found that where only one nurse-child was received for payment, and th foster-mother was consequently without the purview of the Infant Life Protection Act and unvisited by an inspector, the mortality was largely in excess of the cases under legal supervision.

A STUDY OF MORTALITY FROM DIARRHŒAL DISEASES AMONG INFANTS IN ENGLAND AND WALES. (*a*)

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Under the heading "Diarrhœal Diseases" the Registrar-General includes deaths from epidemic diarrhœa, infective enteritis, ill-defined diarrhœa, gastric catarrh, other diseases of the stomach (mainly gastritis), enteritis and gastro-enteritis. These diseases were together in the year 1903 responsible for the death of 19,595 infants under one year of age, the death-rate being equal to 21 per 1,000 births for the whole of England and Wales. About 29 per cent. of the deaths occurred in the first three months of life; 34 per cent. at the age period, three to six months; and 37 per cent. between the age six and twelve months.

The following table (*b*) shows the diarrhœal death-rates of children under one year per 1,000 births in England and Wales, in urban and in rural counties, for each sex separately, and for both sexes together, in the quinquennium 1898-1902 and the corresponding rates for the year 1903:—

	Males.		Females.		Both.	
	1898–1902	1903	1898–1902	1903	1898–1902	1903
England and Wales	35	22	30	19	32	21
Urban Counties	39	26	35	23	37	24
Rura Counties	21	13	16	10	19	11

It will be observed that the rates in urban areas are about double those in rural; that the male rates are in excess of the female; and that the rates in 1903 are in every detail a marked improvement upon the averages of the preceding quinquennium.

The following table (*c*) shows the changes which have occurred in this rate from the quinquennium 1876-80 to the year 1903, the quinquennial periods being expressed as averages:—

England and Wales. Diarrhœal Diseases.

Period.	Deaths under One Year per 1,000 Births.
1876–80	17.0
1881–85	14.6
1886–90	17.5
1891–95	20.9
1896–1900	33.3
1901	34.5
1902	17.0
1903	20.9

The meteorological conditions in the years 1902 and 1903, it should be noted, were exceptionally favourable for a low rate from diarrhœa, and much of the improvement seen in those years had to be attributed to this circumstance. With these exceptions, however, it will be observed that the general tendency of the infantile diarrhœal death rate is towards a substantial increase; and this is most probably to be accounted for by the steady increase in artificial feeding during recent years.

It can be shown that, for the most part, the rate for diarrhœal diseases governs the infantile mortality figure for the year. For example, from the year 1876 to 1900, the lowest rate for diarrhœal diseases was 9 in 1879, and the highest 41·7 in 1899; and the corresponding infantile mortality figures were 135 and 163 respectively; these figures being the lowest but one, and the highest recorded during that period. So, too,

the favourable infantile mortality figures for the years 1902 and 1903 are due for the most part to a diminution in the rates for diarrhœal diseases; the infantile mortality rate of 1902 being 133, and that of 1903, 132.

The infantile death-rate from diarrhœal diseases possesses special interest for the sanitarian. It varies more widely in regard to place, season, and year than does any other infantile death-rate. It is in towns about double that which obtains in the country; late summer and early autumn are the special seasons of its incidence, aggravated in years of special heat and drought.

There can be no doubt that the principal cause of diarrhœa in infants is improper food. Out of nearly 2,000 fatal cases of diarrhœa recorded by Emmet Holt, only some 3 per cent. had been breast fed, and a similar result has been arrived at by Niven, of Manchester (*d*). Hope (*e*) in Liverpool, in 1899, which was a year of high diarrhœal mortality, found that among 1,096 deaths from diarrhœa 20·5 per cent. of the infants had been breast fed. Richards (*f*) found at Chesterfield that only 11 per cent. occurred among children fed from the breast; at Croydon he found the percentage to be 12. Newsholme, in Brighton, from the investigation of 191 fatal cases of diarrhœa in three years 1900-02. which were years of moderate diarrhœal mortality, found that 9·4 per cent. were breast fed (*g*); whilst of forty-four infantile deaths from diarrhœa in 1903, which was a year of low diarrhœal mortality, he found that only 6·8 per cent. of the infants had been entirely breast fed.(*h*)

Probably the explanation of these varying results is to be found in the natural history of the disorders, the breast-fed children being the last to suffer under the conditions generally favourable to diarrhœal mortality. At any rate, the figures amply demonstrate that hand feeding (and therefore it is to be feared improper feeding) is largely responsible.

The *raison d'être* of improper feeding practically opens up the whole question of the factors underlying infantile mortality in general, but here only a few special points in connection with the etiology of infantile diarrhœa need be briefly indicated.

Ballard first drew attention to the connection between earth temperature and diarrhœa. He pointed out in particular that the summer rise of diarrhœal mortality does not commence until the mean temperature recorded by the four-foot earth thermometer has attained somewhere about 56°F., no matter what may have been the temperature previously attained by the atmosphere or recorded by the one-foot earth thermometer; and he concluded that the essential cause of diarrhœa resides ordinarily in the superficial layers of the earth, where it is intimately associated with the life process of some micro-organism. This view has been very generally accepted until recent years. It fails, however, to completely explain the varying incidence of summer diarrhœa in children, and can therefore only be regarded as one of perhaps many other dominant factors. Waldo (*i*) considers that infantile diarrhœa must be regarded first and foremost as the result of strictly local conditions. Newsholme (*j*), after a careful examination of available data, has satisfied himself that the incidence of diarrhœa follows more closely the rainfall than the mean temperature of the air. He believes the relationship of rainfall and diarrhœa mortality to be so close that towns may be classified meteorologically in the order in which they ought to stand in reference to diarrhœa, and their true relative position as to domestic and municipal sanitation may be ascertained when we know whether they occupy a better or worse position on the list of towns than that which their meteorological place would indicate as rightly belonging to them. The greater the rainfall, especially in the third quarter of the year, the lower is the diarrhœal death-rate.

Waldo (*k*) suggests that diarrhœa is largely caused by the pollution of street dust by horse-dung. He says: "In casting around for a possible source of what may be regarded as a manifold infection of epidemic channels the idea occurred to me, as it has to others that organically polluted dust may be the vehicle of distribution. A further consideration of the circumstances of the case led me to the opinion that horse-dung may be the specific polluting material." Admitting this theory, the pollution of milk is readily understandable; the special incidence among hand-fed children is explained; and the decline of diarrhœa after rain (which lays the dust and washes away much of the poisonous material) follows naturally. Town dust is more highly charged with horse-dung than obtains in rural districts, and so the special incidence of infantile diarrhœa in towns is also explained.

Nash (*l*), whilst admitting the coincidence of a rise in earth temperature and diarrhœal mortality, joined issue with Ballard in his conclusion that the essential cause of diarrhœa is a specific micro-organism residing in the superficial layer of the earth whose vital manifestations are dependent upon conditions of season. He believed all evidence went to show that there is no one specific bacterium of diarrhœa. Nash advanced the hypothesis that the common house-fly is the principal cause of summer diarrhœa, and supported it by his experience of epidemic diarrhœa at Southend in the year 1902. During July and August there was no mortality among infants under one year from diarrhœa, as compared with twenty-three deaths during the same period of 1901. July and August of 1902 were comparatively cool months and rain fell on twenty-two out of the sixty-two days. The most remarkable phenomenon of these months was, however, the almost complete absence of *Musca domestica*. Niven (*m*), whilst emphasising the importance of other factors, considers it conceivable that house flies are a means of transmission and admits that the experience of Manchester in the year 1903 is in accordance with such an hypothesis.

All observers, however, are agreed that the essential and fundamental cause of epidemic diarrhœa is bacterial, and that in the case of infants the most common vehicle of this bacterial invasion is milk. It is probable that further bacteriological research will show that all of the factors, temperature, soil, dust, flies, play their part in its production, and that *the rainfall determines the degree* to which they operate.

Delépine (*n*) isolated from milk which caused an epidemic of diarrhœa several bacilli belonging to the colon group. Some of these were very virulent and closely resembled the bacillus enteritidis of Gaertner. In other cases he found a bacillus more closely resembling the bacillus coli of Escherich. He came to the conclusion that the varieties of those bacilli which are most important sources of infection are those which resemble the bacillus of Gaertner, and which therefore (and this is a point of much importance) produce *no permanent acidity, coagulation, or distinct smell when grown in milk*; so that absence of acidity in milk is not, as generally believed, an index of safety.

As regards the source of bacterial infection of milk, Delépine, while admitting that this might occur at the retailer's or in the consumer's home, believed (as the result of his experiments) that it more frequently occurred at the farm or (through vessels) in transit. Newsholme (*o*) on the other hand, is of opinion that milk is generally affected during storage at home in places where it is exposed to infective dust. He investigated the milk supply of 226 fatal cases of diarrhœa which occurred in Brighton in the three years 1900–2. In thirty-five of these cases the milk supply could not be ascertained, or (in four of the thirty-five cases) was derived from mixed sources. Of the remaining 191 cases, eighteen or 9·4 per cent., were breast-fed, and eighty-four, or 44 per cent. were fed on condensed milk. Thus, in over 53 per cent. of the cases of epidemic diarrhœa in Brighton with known milk supply, *domestic infection*, as far as milk is concerned, was alone possible. Great care was taken to exclude from these groups cases in which other sources of milk than the breast or condense d milk were on any occasion employed. The fact also that breast-fed children suffer from epidemic diarrhœa proves that infection

can occur in the home. Newsholme's observation, further, does away with the common belief that condensed milk is a safeguard against epidemic diarrhœa.

From the foregoing etiological considerations of infantile diarrhœa it can readily be understood that most, if not all of the associated factors act in the main through the agency of food; these are—overcrowding, imperfect ventilation, insanitary conditions in and around the house, want of personal cleanliness on the part of attendants and of the infant itself. The probability of insufficient clothing in predisposing to diarrhœa must also be borne in mind.

A high rate from infantile diarrhœa is almost regularly associated with adverse social, hygienic, and industrial conditions acting either directly or indirectly, and goes hand in hand with poverty, ignorance and neglect. The infantile death-rate from the diarrhœal diseases of the Registrar-General must, therefore, be regarded as indicating with peculiar sensitiveness the general hygienic conditions of any community, and above all, has to be taken as an index of the intelligence, solicitude and *morale* of mothers.

(*a*) Part of a thesis for the degree of M.D.
(*b*) Compiled from Table J, Sixty-Sixth Annual Report of the Registrar-General, England and Wales.
(*c*) Calculated from Registrar-General's Reports.
(*d*) Ashby and Wright, "Diseases of Children, 1899," p. 92.
(*e*) Dr. Hope's report quoted by Dr. Waldo, *Lancet*, May 14th, 1900, p. 1427.
(*f*) *Transactions* of Epidemiological Society of London, 1902-03, vol. xxii., p. 43.
(*g*) *Ibid.*, p. 37.
(*h*) "Report on the Health of Brighton, 1903."
(*i*) Waldo, "Epidemic Diarrhœa," *Lancet*, May 14th, 1900.
(*j*) Newsholme, *Transactions* of Epidemiological Society of London, vol. xxii., 1902-03.
(*k*) Waldo, *Op. cit.*
(*l*) Nash, *Transactions* of Epidemiological Society of London, 1902-03, p. 44.
(*m*) Niven, "Report on the Health of Manchester," 1903, p. 168.
(*n*) Delépine, *Transactions* of Epidemiological Society of London, vol. xxii., pp. 11-31.
(*o*) Newsholme, *Transactions* of Epidemiological Society of London, vol. xxii., p. 34.

THE OUT-PATIENTS' ROOM.

FRENCH HOSPITAL AND DISPENSARY.

Cases by Louis Vintras, M.D.

M.S., æt. 22., an anæmic looking young woman is a typical example of the minor breakdowns incidental to long hours, irregular feeding and much standing about, which are some of the inevitable concomitants of our strenuous latter-day life. She came as an out-patient three weeks ago, complaining of loss of appetite, pain in the region of the right ovary, general listlessness, headaches and inability to fix her attention on what she was doing. Her tongue was furred, her eyes were heavy, her lips dry, and there was some tenderness on pressure over the right ovary. She said that she was an assistant in a large shop, where she worked from 9 a.m. to 8 p.m., standing most of the day, and where meals were irregular in that the hours were changed from one week to another. She had been ill for about a week, but had continued at work; these poor workers cannot afford to rest, still less to be ill, and yet a little rest and a little treatment in time saves them so much trouble. This case was only one of anæmia, complicated by nervous prostration. She was put on citrate of iron and quinine and given every night a pill of aloes, belladonna and nux vomica. In about twelve days the tongue was cleaner, the eye brighter, the appetite better. She still complained, however, of headache, and so the treatment was reduced to a grain of quinine twice a day before meals. She is now rapidly improving. This case is one among thousands which show the utility of the out-patient department to which a few timely visits often suffices to check trouble which otherwise might prove serious. This is one of the aspects of the out-patients question which I think is not fully realised by the public at large.

The next patient, A.B., is a woman æt. 36, who works in furs and whose case is interesting from more than one point of view. Between the age of fourteen and fifteen she began to have epileptic fits, falling on the floor and biting her tongue; the fits were not very frequent, sometimes only two or three in a year, and they lasted until she was about 28, since when she has been free from them. She says that she was constantly under medical care during that period, and evidently received the best advice and with excellent results. This constitutes the first phase of her pathological history. The second phase overlapped the first, and began when she was twenty. She noticed then that her eyes grew rapidly tired, she could not read for long, and had a dull pain at the back of the eyeballs, especially the left. A chemist gave her some lotion, which, of course, did not improve matters, and she at last went to Moorfields. On examining her eyes it was found that the sight of the left eye was much impaired, and from what I could gather from her the case seems to have been one of retinitis. She was treated there for some time, and her eyes rapidly improved. She was subsequently given special lenses, which she wore until she was 24, when her sight was virtually so good that she had not needed to wear them since. The third phase of the patient's pathological history began in February, 1905, when after having suffered from violent headaches for several weeks she experienced intense and persistent thirst, and soon found that she was passing water more frequently and in greater quantity than before. She was treated for some time outside, but without relief, and in April came to the out-patients'. She was then passing five quarts of urine in the twenty-four hours, and the thirst was very troublesome. The amount of sugar in the water was comparatively small, and the polyuria was by far the most prominent symptom. She was put on small doses of arsenic, combined with soda and given a grain of blue pill combined with three grains of rhubarb pill every night. By July the quantity of urine passed had diminished to three quarts, by the end of August to two and three-quarter quarts, and by September 30th to two quarts and a half. She had then lost almost entirely the thirst annoyance, and was feeling well and active. For the last six weeks the arsenic had been replaced intermittently by the perchloride of iron mixture. She was so well then that she did not attend the out-patient department again until April of this year. When I then saw her she had a slight return of her symptoms, and the quantity of urine passed was again about two and a half quarts. There was a slight amount of sugar. She has been under treatment since, and is again improving. The quantity passed remains between two and two and a half quarts; the amount of sugar is very small, and the patient's general condition is fairly good. This case is interesting, (1st) in that it presents a perfect pathological sequence, extending over twenty-two years, and originating in some lesion of the brain and manifesting itself in three distinct ways, but all bearing an intimate relation to one another through their common origin. (2nd) The case also points strongly to the theory of the nervous origin of diabetes, a theory towards the establishment of which evidence is each day accumulating. A case I had recently in private practice illustrates this even more strikingly. A lady sub-let a detached part of her business premises, on arriving there one morning she was told that the tenant had not been seen for several days. She had the door forced open, and the man was found dead in the rooms, death having occurred several days before. A few days later she experienced intense thirst, pain in the loins and noticed that she was

passing an increased quantity of water. She came to me, and on examining her urine there was an appreciable quantity of sugar. The attack, which was the result of nervous shock, lasted for about three weeks, and disappeared completely under treatment.

The third case, J. R., is a pastry-cook, æt. 29. In October, 1900, he knocked his left foot against the inside of his right ankle, just behind the malleolus. The blow was followed by a bruise which was out of all proportion to so slight a blow, and his leg began to swell in the daytime. A chemist gave him some ointment, which he says caused the skin to break, and soon there was a large deep sore. He tried all sorts of things for it, and at last went to a hospital in Paris, where he was told the real cause of his trouble—deep varicose veins. With absolute rest and some soothing application the sore healed rapidly. Since he suffers from the fate of all those who have once developed varicose ulcers and whose occupation necessitates long standing; the skin breaks down every now and again, and the ulcer re-forms. It began again a couple of months ago, and is now the size of a sixpence. I only mention the cases as showing the importance of bearing in mind the possible existence of deep varicose veins, when the superficial veins are not enlarged, in the diagnosis of ulcers about the lower extremities.

OPERATING THEATRES.

KING'S COLLEGE HOSPITAL

NÆVUS OF LIP. — MR. PEYTON BEALE operated on an infant æt. 6 weeks, for an extensive and rapidly growing nævus involving practically the whole of the lower lip, extending beneath the mucous membrane and slightly beneath the skin. An incision was made along the lower lip for practically its whole length at the junction of the skin and mucous membrane; the latter was then dissected up freely and the nævoid tissue scraped away by means of a small sharp spoon. Two or three vessels required ligatures, but the oozing was less than would have been expected. All visible nævoid tissue having been thus removed, the flap of mucous membrane, consisting of practically the whole of the lip, was replaced and sutured in accurate position by means of a small curved needle and the finest catgut. Mr. Beale said that wherever it was possible a nævus which was spreading beneath the skin or mucous membrane, and which was not a cavernous nævus, should be freely excised, together with the skin or mucous membrane covering it. This, of course, was quite impossible in the region of the lip in the case of a nævus extending along its whole length. If the nævus were quite superficial, that is not extending deeper than the skin or mucous membrane, it might be treated by the application of pure carbolic or a very finely pointed actual cautery. If on the other hand the nævus was more deeply placed and was of a cavernous type, that is, consisting of spaces filled with blood, it was best treated by electrolysis, the negative pole being placed against the neck by means of a large moistened electrode and one or more steel needles insulated at their bases and connected with the positive pole being inserted into the nævus, a current of about 150 milliamperes being used for about twenty minutes. The case he had just operated upon, however, was not of either of these varieties, and he considered that the operation which he had done was the only thing possible, and he had adopted it in many similar cases with good results: the lifting up of a flap of skin or mucous membrane, scraping or dissecting away the nævoid tissue, and the replacement of the flap constituting the steps of this simple operation.

DISTENDED GALL BLADDER.—The same surgeon operated on a woman æt. about 50, who had an obviously enlarged gall bladder; it could easily be felt on palpating the abdomen, and moved with the liver during respiration. She was deeply jaundiced and complained of intense pain about the region of the gall bladder. She had had several previous attacks of jaundice accompanied with the same pain, and it was supposed that she had a gallstone impacted in the common duct. The abdomen was opened over the region of the gall bladder, and the latter was immediately seen, the part visible being as large as a goose's egg. Precautions were taken that as little as possible of its contents should find their way into the abdominal cavity, by packing the wound with gauze. The gall bladder was then freely opened; the fluid which escaped was of about the consistency of thick gum water, colourless and perfectly clear. The interior of the gall bladder was carefully examined by the finger and then by means of a long probe, but no stone or other source of obstruction could be felt. The gall bladder was then washed out and the hand passed into the abdominal cavity. The whole of the region at the back of the liver and round about the common bile duct and the duodenum was carefully explored, but no stone could be felt, nor could any cause of obstruction of the duct be made out. It was, however, noticed that there was a very ill defined "matting together" of all the tissues and structures at the back of the liver, and that the latter organ was actually pushed forwards as the result; the right kidney also appeared to be displaced through the same cause. The patient's condition did not admit of any thorough investigation, so the opening in the gall bladder was sewn up and the abdominal wall closed except where gauze drains were left around the gall bladder. Mr. Beale remarked that he was quite at a loss as to the cause of the obstruction in this case; it was clear that there must be something obstructing the bile duct and the common bile duct, for no bile was entering the gall bladder nor could the clear fluid within it escape.

The patient died two days after the operation, and at the post mortem examination it was ascertained that the matting together of the tissues which was felt at the back of the liver at the time of operation was due to the existence of a large ulcer in the duodenum. The ulcer was excised for microscopical examination, and from its size and from the appearance of its edges it was supposed to be malignant. In all probability the pain from which the patient suffered was due to the presence of the ulcer, although there were no other symptoms whatever pointing to its presence.

ROYAL FREE HOSPITAL.

TWO PRIMARY CARCINOMATA IN THE INTESTINAL TRACT.—MR. JOSEPH CUMMING operated on a man æt. 51, who had been admitted with the following symptoms:—During the last twelve months he had suffered from attacks of pain not confined to any special area of the abdomen, but radiating all over it; these attacks of pain lasted two or three days, and were accompanied by constipation and occasionally by vomiting; he never had attacks of diarrhœa, and never passed any blood. On examination, the man was rather thin, and looked ill; he had lost twelve pounds in weight in the last year. The abdomen was soft and not distended, and there was some tenderness in the epigastrium. During examination coils of intestine could be seen in peristaltic action, but no

lump could be felt anywhere in the abdomen. In view of these symptoms Mr. Cumming said he had come to the conclusion that the case was one of chronic intestinal obstruction, most probably due to a carcinoma. He pointed out the fact that a very common situation of carcinoma was the sigmoid, and that a common feature of growths in this neighbourhood was the impossibility of feeling them through the abdominal wall, owing to the small size of the growth, even when producing complete intestinal obstruction. There was nothing, he said, beyond probability to give any guidance as to the situation of the tumour. He intended after opening the abdomen to first examine the sigmoid; if he found nothing there, to trace the colon backwards until the site of obstruction was found; then, if the growth were removable, he proposed to excise it, if not to anastomose the intestine above the site of obstruction to the intestine below it, so as to relieve the symptoms. The abdomen was opened through the left rectus, and small intestine very much hypertrophied and dilated presented. The collapsed sigmoid was pulled up through the wound, but no sign of growth was found in it. However, on tracing it upwards, when the middle of the transverse colon was reached a tumour was found, but on bringing this out through the wound it was seen to be growing from the greater curvature of the stomach. There were some glands in the gastro-colic omentum, and the upper wall of the transverse colon was invaded with a small patch of growth. The removal of the growth was now considered possible, but, as there was nothing to account for the hypertrophy of the small intestine, further examination was deemed necessary before proceeding to perform such an extensive operation. On examining the region of the cæcum a second tumour, which was evidently the real cause of the obstruction, was found in the last foot of the ilium. For about two inches in this neighbourhood the intestine was converted into a hard cord about the thickness of a thumb, the gut above being dilated and the gut below collapsed. There was so much infiltration of the mesentery and of the mesenteric glands that it was impossible to think of excision, so a palliative operation only was decided upon. A lateral anastomosis was performed between the ilium and the sigmoid. This was rapidly done in the usual way by direct stitching, and the abdomen closed. Mr. Cumming remarked that this case showed very well the fact that it was wrong to wait until a tumour could be felt in the abdomen, if there were signs of chronic obstruction, such as this man presented. An extraordinary feature of this case, he pointed out, was that the patient had two separate and distinct primary growths. It also showed, he thought, how easily one might fall into error; supposing he had been content with finding the growth in the stomach without looking for the cause of the dilatation of the small intestine, then partial gastrectomy would have been performed, and the patient still left with intestinal obstruction. As had been seen, the anastomosis by direct stitching had only occupied thirteen minutes, this being very little longer than the time occupied in union with Murphy's button, but it had the advantages, he considered, of providing a very much bigger opening, a safer method of union and no mass of metal to get rid of.

The candidates elected to represent the Faculty of Medicine in the Standing Committee of the University of London are Miss Aldrich Blake, M.D., Dr. Sansom, and Miss Vaughan, M.D.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Aug. 26th, 1906.

Hiccough.

Hippocrates attributed, says M. Fiessenger in the *Journal des Practiciens*, a very sombre prognosis for obstinate hiccough; the opinion is certainly true in the case of imminent death. But hiccough in itself is not a very grave affair. It can be observed in the course of all kinds of maladies as a purely nervous symptom. Last year we were called to a patient in the country suffering from intense hiccough, a man who was seized with dyspeptic troubles accompanied with great pain. The spasmodic contractions followed in rapid succession for twenty-four hours. A warm bath for one hour and a few drops of a solution of morphine and atrophine quickly relieved him.

Each time that in the course of any malady hiccough appears, the attention of the attendant should be drawn to the degree of nervous excitability of the patient. Hysterical hiccough is well-known. It may last weeks or months, and disappear in the end abruptly or is replaced by some other manifestation of same origin. Persuasion and hydrotherapy will generally effect a cure. Besides this kind of hiccough of nervous origin, there exist several other causes, reflex or central.

The reflex causes generally observed are due to affections of the digestive tract, the peritoneum, the liver, urinary organs, lung, pleura, pericardium, peripheric nerves. The hiccough of gastro-intestinal origin is very frequent, especially in very young infants. It is due to an over-charged stomach, and which proper attention to the method of feeding will overcome. In adults hiccough is frequently due to dyspepsia from hyper-acidity of the stomach. The following solution acts frequently like a charm—

Hydroch. of morphia, 0·10 centigr.
Sulphate of atropine, 0·01 centigr.
Chloroform water, 12 grammes.

Three drops every two hours in a teaspoonful of water six to eight times in the twenty-four hours. The warm bath should be prolonged one hour. In ulcer of the stomach or cancer the same treatment can be used with benefit, and a small blister applied to the epigastrium, or an ice bag.

In peritonitis, hiccough is very frequent as well as in intestinal occlusion. For the former, repeated injections of small doses of morphia and the ice bag are the best treatment, while for the latter, belladonna should be given, as it acts both on the symptom and the malady.

Extract of belladonna, ¼ grain.

For one pill, one every hour for six hours, afterwards one every two hours.

Hiccough has been frequently observed in hepatic colic, especially in women. It can be relieved by a warm bath, the ice bag, and a mixture containing ether and morphia.

In certain maladies of the respiratory organs, pneumonia, laryngitis, whooping cough, asthma, pleurisy and particularly diaphragmatic pleurisy, hiccough is often a trouble to the patient, but yields to injection of morphia.

Hiccough of central origin is frequently emotional, and for which all kinds of remedies have been proposed with more or less success, a pinch of salt, or sugar steeped in vinegar on the tongue, forced inspiration, suspension of the respiration, compression of the wrists, projection of the tongue as far as possible out of the mouth, fright, etc.

The hiccough of certain infectious maladies is otherwise grave. That observed in typhoid fever is frequently accompanied by vomiting and the condition of the patient becomes imperilled; the same may be said of

scarlatina, scorbutus, cholera. Abundant drinks, baths (77 F.) injections of camphorated oil, and quinine constitute the treatment.

The hiccough of abundant hæmorrhage which precedes syncope, and that of cerebral affections (traumatisms, meningitis, cerebral hæmorrhage, tumours), is only a symptom and requires no special treatment.

In conclusion I will say that hiccough is only grave when it is accompanied by a very bad general condition of the patient.

CHRONIC METRITIS.

The following will be found a very efficient remedy:

Arseniate of soda, 1 gr.
Iodide of potassium, 1 drachm.
Water, 10 ounces.

Two tablespoonfuls a day for ten days, after which:

Ergot of Leigh, 3 gr.
Powder of Colombo } 5 gr.
Powder of Cinnamon }
Powder of carbonate of iron, 2 gr.

For one wafer; twice daily.

GERMANY.

Berlin, Aug. 26th, 1906.

AT the Freie Vereinigung der Chirurgen, Hr. Katzenstein discussed the

CHANGES IN THE CHEMISTRY OF THE STOMACH AFTER GASTRO-ENTEROSTOMY.

For the purpose of studying the question with greater exactitude he had found gastric fistula in dogs, and had then investigated the gastric processes before and after performing gastro enterostomy. He ascertained the following facts:

After all kinds of gastroenterostomy both bile and pancreatic juice freely found way into the stomach, in the earlier stages they were always present, but later only following certain phases of digestion.

The acidity of the stomach was distinctly reduced by the inflow of alkaline intestinal juices, first in consequence of chemical changes and then also of diminished formation of acids.

Pepsin in a neutral reaction was without activity: the ferment of albumen of the pancreatic juice, the trypsin, was only weakened by transient acid reaction; diastase and the ferment of fat acted also in an acid medium, but less powerfully than in an acid one. After gastro enterostomy, therefore, in the first instance, digestion was dependent on this resistent pancreatic ferment.

The secretion of pancreatic juice and of bile could be increased in a reflex manner by introduction of fat into the stomach (this had been observed also in the human subject).

In this way the acidity of the stomach can be reduced at will after gastro-enterostomy.

THE ÆTIOLOGY OF FATTY TISSUE-NECROSIS AND HEPATIC CHANGES AFTER INJURY OF THE PANCREAS.

A preliminary communication on this subject has recently been made by Professor Page and Dr. Martina, of Graz, in the *D. Zeitsch. f. Chir.*, 831 and 2. The authors say that although light has been thrown on the ætiology of necrosis of fatty tissue well known to follow injury to the pancreas, the subject in some of its aspects still remains in the dark.

The facts determined by the writers are:—(1) That the necrosis in question is caused, as a rule, by contact with the out-flowing pancreatic juice. The more the possibility of such contact is diminished the less necrosis there will be. Hæmorrhage into the fatty tissue precedes the action of the fat-splitting ferment. (2) The amount and rapidity of the necrosis are in direct proportion to the amount and quality of the food taken in. During digestion and copious ingestion of fat the necrosis is most marked; during fasting it is less, and continues so so long as food is withheld. (3) A small proportion of the necrosis met with during experiments on animals arose through embolisms, by invasion of the blood vessels by cells of the pancreas. Whether pancreatic cells could be conveyed in a similar manner along the lymph tracts with similar consequences, as stated by some, was not determined; but the author met with absolutely nothing that could lend support to such a view. Possibly the number of embolic necroses in the human subject was in consequence of easy vulnerability of the retro peritoneal situation of the pancreas, the firm capsule, the possibility of the close shutting off of the bursa omentalis as contrasted with the free entrance into the abdominal cavity. (4) The embolic necroses differed from those brought about by direct contact in various ways, amongst others by a later onset of the necroses. No time limit could be determined, but it appeared as if several days were required to bring them about, when necroses from contact were visible after two hours.

They were also localised in the immediate neighbourhood of a vein, so that at first they could only be seen on a section of it, and they did not reach the surface of the part affected. If the cell embolism was large, however, if there was much steapsin, and if a longer time had elapsed, they did appear on the surface, and they were then no longer distinguishable from contact necroses.

By the microscope also they were distinguished by the discovery of pancreas cells in the vein—these cells were found in clotted blood, sometimes individually, sometimes in accumulations. Valuable as this proof is it is not always positive, as the pancreas cells die off and become lost to sight if they remain long in a vein. A negative result, therefore, in a microscopical examination does not absolutely disprove an embolic origin.

Typical necrosis was induced by the injection of very finely saturated pancreas tissue into fatty tissue, or into the blood channels. The former always arose from contact, the latter in the immediate neighbourhood of the vein injected, and later on the fatty tissue adhering to it.

The liver showed great patchy changes both in the periphery and centre in the form of indistinct outline of acinus or complete absence of it. A part of these changes was almost certainly brought about by an embolic route, but the greater part by the pancreatic ferments reaching the liver in the blood.

To the objection that the experiments were performed under conditions not likely to be met with in the human subject, they point out that injury, hæmorrhage and inflammation might easily set up the conditions. Moreover the conditions for the development of fatty embolism and consequent fatty necrosis were more favourable in the human subject than in the animals experimented on.

In any case they must claim it as proved that fatty necrosis can be set up by embolisms.

AUSTRIA.

Vienna, Aug. 26th, 1906.

SCOPOLAMIN-MORPHIA INJECTIONS.

LOCAL anæsthesia has been the pursuit of many medical scientists of recent years, and still the subject is unsatisfactory to the surgeon. Rys, of Prague, records one of these experiments with scopolamin-morphia. Scopolamin is obtained from the root of a solanaceous plant, "Scopolia atropoides," or "Japonica" when obtained from the Japanese plant. It is an isomer of hyoscin, atropine, and hyoscyamin, with a formula of C_{17} H_{23} NO_3, and is an isomeric alkaloid of tropin. It is a mydriatic and sedative like atropine but shorter in duration. Scopolamin hydrobromic, has been used freely of late hypodermically as a sedative, and hypnotic, but its combination with morphia is in the experimental stage and requires a few victims before its value can be established.

Rys desired to remove a lymphoma from the neck of a youth, æt. 16, for which purpose he narcotised locally by injecting half a syringe full of a solution of scopolamin and morphia, which would contain 0·25 gramme of morphia and 0·01 of scopolamin hydrochlorate in 10·0 grammes of distilled water, *i.e.*, 3·85 grains of morphia, and 0·54 of scopolamin in two drachms of water. Seven minims of the solution would contain about a quarter of a grain of morphia and 7–6,000

of scopolamin. After the injection the boy went to sleep, but the pain of the operation speedily awoke him. In the course of an hour another injection was given and the operation completed with a little chloroform as he was very restless. The operation being over, the boy went to sleep, having received 0·77 grain of morphia and 0·015 of scopolamin. He slept quietly till four o'clock the following morning, when the nurse aroused the indoor physician to come at once, as the boy was having fits or convulsions, and she said he had never been awake since the operation the day before. The doctor found the lad in a deep sleep with reflex of body quite active, though absent in the cornea, and the pupils acting sluggishly. At short periods toxic convulsions were observed, breathing irregular, temperature 40·9° Cent., and pain on pressure over the body. To relieve the convulsions tincture of musk was injected with the desired effect of checking the spasms. The boy still slept, but the pulse was now very feeble and more rapid.

The physiological solution of salt was injected to the extent of 500 grammes, which improved the pulse for a time, but it speedily relapsed again into the weak condition. The salt solution was injected three times more with temporary improvement, while musk was used in the intervals, but the breathing still became weaker, which half an hour's artificial respiration did not improve. In spite of every effort the boy died about 11 o'clock, or twenty-four hours after the operation.

Rys thinks this should warn operators against using this local anæsthetic, as the above is not an isolated case of scopolamin-morphia narcosis.

Orthostatic Albuminuria.

Pelnak has recently been devoting his attention to the subject of albuminuria with the following results: Immediately the change of the body is made from the horizontal to the vertical, the arterial blood pressure is lowered and the pulse frequency increased, and remains so as long as the upright position is maintained; and during this period there is oliguria with increased specific gravity of the urine.

His experiments were conducted on sixteen young persons ranging from 12 years to 23, of which nine showed neuropathic symptoms and degenerative changes, being pale, with cardio-vascular irritation; seven suffered from the after effects of infectious disease, such as scarlet fever, etc. No symptom of renal disease was present in any of the cases, though six of them had hyaline and granular cylinders in the urine. None of them exceeded 2 per cent. of albumin.

As soon as the horizontal position was restored the pulse fell to its normal frequency with increased pressure without any dicrotism, which is usually present in the upright position. During this period the oliguria is converted into polyuria with a normal specific gravity. In order to confirm this low arterial blood pressure in connection with albuminuria he experimented with several drugs known to produce the desired effect, but all tended to prove the facts already stated. The blood pressure remained constant, the quantity of urine and chemical constituents remained the same. Cold baths made no change when movement of the body was prevented.

This pulse acceleration agrees with Thomayer—orthostatic tachycardia probably due to vasomotor irritability. The predisposing cause is neuro-asthenia or any weakness in the vasomotor system.

In all the cases examined the albumin disappeared from the urine as soon as the variation of pulse and blood pressure disappeared. The albumin is not permanent in the urine unless there is an anatomical cortical lesion in the kidney, but nothing of this sort existed in any of the cases operated on.

A young girl has died of cholera in Berlin. Measures have been taken to ensure the disinfection of the premises where the death occurred.

CONTINENTAL HEALTH RESORTS.

Aix-les-Bains.

[from our own correspondent.]

This Spa has a two-fold celebrity.

1st.—As a Mineral Water Station, justly renowned for the efficacy of its Springs, the beauty of its situation, its unquestioned sanitation and salubrity, the completeness of its Thermal Establishment, and the ability of its physicians.

2nd.—As a Pleasure Resort, unsurpassed in France for the variety of its summer entertainments and amusements.

In July and August its pleasure-seeking throngs out-number and throw into the shade its invalid *clientele;* but in May, June, September, and sometimes even early October (really the most agreeable months for climate here), the real *raison d'etre* of Aix-les-Bains has the predominance it merits. For after all, the genuine and enduring prosperity of Aix lies in its remedial waters, the inherited skilfulness of its masseurs, and the thorough knowledge of its medical practitioners of how best to use in each individual case its waters and appliances. Take away its Springs, Baths, and medical science, and the summer gaieties of Aix-les-Bains would fade away like the radiance of one of its lovely summer evenings.

It is well that its physicians do so thoroughly know what to do and what to leave undone; for, despite the many years' world-wide repute of Aix, every season invalids are sent here for treatment who should have been sent elsewhere. The profession who recommend patients to Continental baths sometimes overlook the *contre-indications* of each special Spa.

At Aix-les-Bains are two hot Springs, the Sulphur and the Alum Springs; the last really containing no alum. The two Springs combined supply to the bath establishment over 2,000,000 gallons every twenty-four hours. Both Springs are sulphurous, containing equal quantities of hydrogen, with additions of carbonates of iron, of magnesia, and of alumina. Their temperature varies from 110° to 115° Fahrenheit. By the Dupasquier sulphydrometre they show 4°. The treatment is essentially external, varying from many other thermal treatments by its massage under the douche. This *douche massage*, so far as Europe is concerned, originated here, and in its perfection is only administered here. Although imitated now in many places (where "Aix massage by Aix masseurs" is much advertised), the presence of a curious organic substance, *barégine*, gives to the waters here advantages in rubbing and kneading the muscular structure not found elsewhere.

The *Bouillon* (general vapour-bath) and the *Bertholet* (local vapour-bath) are also much utilized; the latter, named after a well-known Savoy chemist, and being peculiar to Aix-les-Bains.

The hill-side location and the arrangement of the Thermes afford to the physician precise control of temperatures and pressures, the pressure varying according to the position of the bath-rooms, the forms of these rooms being also designed to correspond with the kind of bath to be given therein.

At Marlioz (ten minutes from Aix) are cold sulphurous Springs, very efficacious in diseases of respiratory organs. Near the Public Park is an excellently equipped Zander Institute. And on heights around Aix are alkaline waters, growing in popularity more and more for table use and for internal lavages.

A dispute has arisen among the municipal authorities at Madrid on a question of public health. The sanitary commission ordered that 53 dairies in various parts of the capital should be closed, and the committee of the municipal council refused to agree. A great deal of feeling has been aroused by this action.

LETTERS TO THE EDITOR.

TRANSMISSION OF SYPHILIS.

To the Editor of THE MEDICAL PRESS AND CIRFULAR.

SIR,—"An Average Practitioner," in this week's MEDICAL PRESS AND CIRCULAR, comments on Jonathan Hutchinson's lecture of last week, regarding "Transmission of Syphilis to the Third Generation."

Allow me a few words on this point not discussed by either of the gentlemen.

The history of syphilis in Japan (where I have had some practical experience with syphilitics of every class from the emperor's class to the outcast Eta (curly headed negroid) and the leper, even with the Aino, the white indigene of the Agricultural School Kaitokushi (of Hakodade), shows that there not only syphilis is transmitted to succeeding racial generations, but a measure of immunity as well. For 1,300 years at least that race has been saturated with syphilis. Syphilization has been honoured as a practice since the twelfth century of our Era, that is for seven hundred years. For then the Miniamota family captured all the Taira women (two rival families, for representation in the Mikado's office) and cast them into prostitution. Thus it came about that to seek one's wife, among the prostitutes, brought noble blood to one's family. Even the occurrence of syphilis in the prostitutes was considered a sign of nobility. Hence syphilization became significant of having Taira blood, in the family veins. Japanese reasoned that the family which was syphilized obtained a natural resistance to the disease. This theory, they also applied to vaccination and small-pox. It was this method of reasoning which provoked the greatest opposition to vaccination when introduced in 1849. A child of one who had had syphilis, or small-pox was not as apt to develop a virulent type of either disease when inoculated. Now, when an European is inoculated with the germ of syphilis of Japan he shows a virulent type of the disease, much more than does the Jap, who has been associated with syphilis for nine hundred years longer than the Western European, unless we count the lepers of the Madeleins of the crusade centuries as syphilitics and not lepers.

At any rate, Western Europe has known syphilis since 1472. while Japan has known it since the Korean and Mongol invasions. The Japanese have acquired a distinct measure of immunity against the ravages of the disease, if not against inoculation. Here is an advantage transmitted to the third and succeeding generations. Of course the Japanese have always been known for their Chinese teachings, the advantages of therapeutics, especially mercury, Kaifun (calomel), 724 A.D. Cinnabar (Chinese) fumigations. Corea nose stuffings of mercury as well as iodized sea-weed and other iodized foods and medicines. But they got, probably a large part of their good result of resistance to syphilis from the use of arsenic baths. Had the transmission of syphilis to the third generation been entirely malign, the Japanese race should have died out long ago, or it would have operated to make the race such a crowd of weaklings that it could not have accomplished anything of the kind that it was in its subsequent destiny.

The innate sensuality of this race of negroids, Malay and Mesopotamian Africans, mixed with the Negrotoid and Mongolian must have caused them to contract what Dr. Marshall, as quoted by Mr. Jonathan Hutchinson calls "primary syphilis" wholesale. Yet there does not seem to have resulted any rapid degeneration of the population due to it. I agree with Mr. Hutchinson entirely, the influence of syphilis on a population is very small, it is even born by the advantages. Of the antagonism or immunity transmitted to the new-generations. "It is not the cause of degeneration at all."

I am, Sir, yours truly,

ALBERT S. ASHMEAD, M.D.

New York, Aug. 16th, 1906.

THE FREE PORTRAIT TRICK.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—With reference to your comment on the "Free Portrait Trick" which appeared in your issue for August 15th, may I recount my experience *re* Mr. Tanqueray of Paris. I went through all the stages, that your colleague did, but unfortunately I went further. I purchased one of his frames, to be sent with the picture price £1 8s., which amount was to cover packing, carriage, etc. Although he had written previously to say that the magnificent photo was ready to forward, four weeks elapsed before it arrived, and then I had 5s. 3d. carriage to pay at the railway station. Of course I had no option but to pay, as I had already forwarded a cheque for the £1 8s. I got the station-master to write requesting this amount to be refunded. I wrote myself enclosing copies of his communication and threatening exposure if he did not pay, but no reply was ever received. I give you this information for publication, fearing that others may be duped in a similar way, and if I prevent the sale of one photo or frame it will be a satisfaction. Hoping you will find space for insertion of this communication.

I am, Sir, yours truly,

J. P. FALLS.

Red House, Carrick, Aug. 20th, 1906.

[Another correspondent informs us that in response to Tanqueray's circular he sent a photograph to him, and shortly received a notice saying his portrait was ready. Happening to be in Paris a few days later he called at Mr. Tanqueray's "studio" and asked to see it, saying he would take it away with him. He was told that it was undergoing some important finishing process and could not be seen just yet. A week or ten days later he called again, having in the meantime received another letter saying that his portrait was waiting and was very beautiful. However at the "studio" it was still invisible. Our correspondent then explained to Tanqueray what he thought of him, with the result that he got back the photograph which he had sent, but no portrait. Under the circumstances, we have no hesitation in warning those who may have received Tan queray's circulars to have no dealings with him.—ED.]

THE DECLINING BIRTH RATE.

To the Editor of the MEDICAL PRESS AND CIRFULAR.

SIR,—Your correspondent "Imperialist," need not I think regard with any concern those pessimistic preachers who are wont to be on the look out for some calamity, as I believe they are entirely off scent. So far from viewing this decline as detrimental there is greater reason, I fancy, to look upon the question as one for national, international, and in many instances individual congratulation. As a matter of fact, the evil which is supposed to exist does not in reality exist at all, simply because we may fairly infer that so long as the supply of population exceeds the demand, a condition which there is evidence to show at present exists, so long will it be to the advantage of the British Empire that some system of decimation should be at play; in other words, so long will it be necessary for our population to go on declining.

The evils which are imaginary in the declining birth rate, are not in reality centred in this decline. On the other hand, they are to be sought among the causes which underlie (these undoubtedly are serious and complex), and which induced or initiated this decline. It should therefore be the aim of those off scent, as I have remarked, to seek out such factors necessitating the decline, begging the question of necessity for one moment.

I have already stated that the supply of population is greater than the demand at the present day, and this notwithstanding the decline has been continuous and uninterrupted the last few decades. There is, I submit, incontrovertible evidence to prove this. This evidence consists of the fact that we are at the present moment face to face with a surplus and ever-increasing

population with which we are at our wits' end to know how to disgorge, these consisting of the unemployed and the unemployable. Further we have the evidence of General Booth and moreover the Church Army that emigration is the most effectual means to cope with the dilemma. This again means the exportation and drainage of the best blood from our own shores to foreign climes, the colonies, as might be expected, refusing the refuse. I ask, hypothetically, on the face of all this, what might have been the state of things had the ratio of population been reversed, that is to say, supposing increase had taken place in lieu of decrease during the period of decline. Surely, there is here sufficient evidence to prove the beneficial results of a declining birth-rate up to the present hour, without suggesting the suicidal policy of increase. If so, why lament its decline? It is certain nothing could paralyse or revolutionise any race, either highly civilised, or semi-civilised, and lead to degeneration sooner than an unmanageable and uncontrollable population.

In conclusion, sir, I am aware how frequently it is urged on grounds of political economy or sociology, that a declining birth rate affords index to the degeneracy of a race. This may be so in history. Even here the declension was probably concomitant with, rather than the cause of degeneracy. However, considerations of this kind are but moonshine with us. The British nation knows full well that numerical strength with her, except under very wide limits, counts for little or nothing; overruling territory so vast, it cannot be by virtue of number, but rather through moral and intellectual forces, whilst like the other leading powers of the world she derives her bodyguard from international jealousy and the great bone of contention, viz., the balance of power.

I am, Sir, yours truly,

Clement H. Sess.

Brighton, August 24th, 1906.

FANGO DI BATTAGLIA.

To the Editor of The Medical Press and Circular.

Sir,—Our attention has been drawn to a letter in your issue of Aug. 22nd, signed G. Harbinson, M.B., to the effect that the writer of the article on Matlock Bath was in error in stating that treatment by Fango di Battaglia can, at present, only be obtained at Matlock Bath. We can state, however, that he is substantially correct, because for the past three years we have only supplied Fango to the Royal Baths, at Matlock Bath, with the exception of small quantities for experimental purpose to hospitals, etc.

It is true that some three years ago we sent a small consignment to Smedley's Hydro, from which Institution Dr. Harbinson dates his letter, but we assume that this has long since disappeared. If the quantity sent has been, as your correspondent states, "in use for the last three years," we can only say that it must have long ago exhausted its usefulness, as it should be used only once and then thrown away.

It is so important that the treatment should be properly given, and that its supervision should be entirely in the hands of medical men, that we have preferred to limit its use either to the public baths of spas, or to establishments where we know the conditions to be quite favourable.

At Matlock Bath special provision has been made for Fango treatment; the mineral water is admirably adapted for storing it and the douches are arranged with special consideration to convenience in its administration.

As stated in your editorial note Fango is the Italian for "mud" and there are many kinds of Fango, but only one Fango di Battaglia. It is the mineral deposit from hot volcanic springs at Battaglia, and has been used continuously from the earliest ages for the relief of painful arthritis, neuralgia, etc. It is not to be compared with Fango which is supplied as a substitute and is often the mud from the bed of a river or pond The decayed organic matter and possible sewage contamination in these substitutes render them unsuitable and even dangerous.—I am, Sir, yours truly,

For the British Fango di Battaglia Co.,

G. Vetter, Manager.

Mark Lane, E.C., Aug. 27th, 1906.

OBITUARY.

THOMAS NEWBY, M.D., Lond.

Regretfully we announce the death of Dr. Thomas Newby. A native of Grimsby, having been born there some sixty-six years ago, he was sent first to Lord Brown's school. From there he proceeded to college, eventually taking his dgeree as M.D. at the London University.

One of the first public appointments he secured was that of Police Surgeon to the Borough Force, but on the town deciding in 1872 upon the necessity of a medical officer of health, he resigned that position, and became Grimsby's first medical officer, an appointment he held up to the time of his death. He was also the port medical officer, in which office he had the supervision of the cholera outbreak some years ago; he was the medical officer under the Aliens Act, and also medical officer to the Cleethorpes Urban District Council. The most striking feature of his medical character was his enthusiasm for sanitary reform. Dr. Newby was the oldest practitioner in practice in Grimsby, and his death, coming so soon after that of Dr. Allen's, has made a very big gap in the local medical ranks.

FRANKLIN HEWITT OLIVER, L.R.C.P., L.S.A.

Dr. Franklin Hewitt Oliver, of Kingsland-road and Clapton, a prominent medical practitioner in North-East London, died during last week at the premature age of 47. Dr. Oliver held numerous public appointments, including that of surgeon to the G and H divisions of the Metropolitan Police. He was one of the pathologists selected for London inquests, and was surgeon-accoucheur to the City of London Lying-In Hospital.

JAMES P. DRINKWATER, M.R.C.S., L.S.A.

Dr. James Pratchett Drinkwater, one of the best-known of the Welsh medical officers of health, died at Llangollen on August 23, at the age of 78. He had been medical officer to Llangollen Town Council for upwards of forty years, and held several other important public positions in the county. As a doctor in the service of the Cunard Company prior to settling in Wales, Dr. Drinkwater had crossed the Atlantic more than 100 times, and was well known to Transatlantic passengers, both in England and America. He took the M.R.C.S., Engl., in 1852, and the L.S.A. in 1862.

DR. MARGARET SMITH BELL, L.R.C.P., L.S.A.

Whilst spending a holiday at Portrush with her husband, Dr. J. Douglas Boyd, of Oldham, Dr. Margaret Smith Bell became seriously ill with a throat affection, and though two operations were performed at Belfast, she unfortunately died on August 21. Mrs. Bell was a daughter of a Newry gentleman. Graduating at the Irish colleges she came to Manchester in 1893 and built up a large practice. She became a co-opted member of the committee of the City Council in the registration of midwives, and was highly respected in the city by a large circle of friends.

JOHN CAMERON, M.D., F.R.C.P.

Dr. John Cameron has died at his residence at Liverpool at the age of 88. Dr. Cameron studied at Dublin and Glasgow and qualified as a licentiate of the Royal College of Surgeons, Edinburgh, in 1839, and took the M.D. degree at Glasgow in 1843. In 1859 he was admitted a member of the Royal College of Physicians, London, and in 1873 elected a Fellow.

MEDICAL NEWS IN BRIEF.

Honours for British Medical Men.

AT a special convocation of the University of Toronto the honorary degree of LL.D., *honoris causa*, was conferred upon Professor Thomas Clifford Allbutt, A. H. Freeland Barbour, Sir Thomas Barlow, Sir James Barr, Sir William Broadbent, George Cooper Franklin, William Dobinson Halliburton, Sir Victor Horsley, Donald MacAlister, William Julius Mickle; Louis Lapicque, Paris; Ludwig Aachoff, Marburg; and W. J Mayo, President of the American Medical Association. The degree was also conferred, *in absentia*, upon Dr. H. W. Langley Browne, chairman of the British Medical Council. Dr. George C. Franklin, Leicester, the retiring president, in acknowledging the honour on behalf of his associates in surgery, said they had found the techniques of antiseptic surgery in Canada to have reached a completeness and thoroughness which he hardly thought was to be found throughout England. He would go back to England knowing that the surgeons on this side of the Atlantic were among the very foremost of the world. It was announced that the McGill University, Montreal, would confer the degree of LL.D., *in absentia*, on Sir Thomas Barlow, Sir William Broadbent, Professor Allbutt, and Sir Victor Horsley.

Lord Cobham and the late Dr. Corbett's Estate.

THE annual meeting of subscribers to the Corbett Hospital, Stourbridge, was held at the Hospital on August 20th, the president (Viscount Cobham) being in the chair. The annual report of the Board of Management, after expressing regret at the death of the late Dr. Thomas Corbett, paid a tribute to the interest which that gentleman always took in the hospital. Lord Cobham, who moved the adoption of the reports, is one of the trustees under the late Dr. Thomas Corbett's will, and he made an important statement regarding the disposal of that part of the estate which had been left for philanthropic objects. The late Dr. Corbett, he said, had shown as great an interest in the hospital as did his brother, its founder, and when in his lifetime they brought before him plans for increasing the accommodation for women they felt confident that he would see them through the expense of the additional building entailed, and also through a great deal of the very heavy maintenance charges which such an extension meant. Unfortunately he died before matters could be arranged. Under the late Dr. Corbett's will there was a sum of money which was left for disposal by the trustees among charitable and philanthropic objects, and the Board of Management made a carefully prepared application for submission to the trustees. A very large sum of money, nearly £100,000, had been left to specified objects.

Death from Anthrax.

AT Bingley, on August 20th, an inquest was held on the body of George Garthwaite (56), wool-washer, who died at the Bingley Cottage Hospital, anthrax being suspected as the cause of death. Mr. T. C. Taylor, His Majesty's factory inspector, of Leeds, was present during the proceedings.

Margaret Garthwaite, the widow, stated that her husband had been employed by Messrs. G. Ackroyd, jun., commission wool-combers, Stanley Mills, Bingley, for the last four months, and had previously been a weaver. On Monday, the 13th inst., he complained to her of a pimple on his left wrist, but he went to his work that day. On the following morning the foreman, hearing something of this, examined the pimple, and then sent him to a doctor, and next day he was removed to the hospital.

Abraham Hird, the foreman at the works said that on Monday, the 13th inst., the deceased was handling East Indian wool, a kind which did not smell badly, and was rather greasy. The deceased had worked on East Indian and English wools and mohair.

Mr. George Ackroyd said he was a member of the Investigation Board in Bradford which was trying, at considerable cost, to find where the anthrax came from, and how it could be prevented. When this case occurred he consequently tried to find out what materials had passed through the man's hands, and he had had a list made of all the materials he might possibly have handled. These materials were East Indian wool, English wool—which were not injurious—and Cape mohair. The mohair had been sorted before received, except for one lot of mixed Cape mohair. This was received in bales, but many of these bales had been handled, having been made up of various lots and repacked. He believed the dustiest lot of material would be this Cape mohair, but none of the material was very dusty, and as far as smell went there would be no bad smell. As to the dust, he did not think it would be as stated, and could only appear to give a shower of dust if held up in sunlight. It was rarely that any sorting was done at his place, and none of this material was sorted, except that which was so dealt with after working. He added an expression of deep sympathy with the deceased's widow.

Dr. M. Crocker, of Bingley, said he was away when the deceased first came under treatment, and he first saw the man on the 17th inst. There was a typical pustule on the front of the left wrist, and from the first he had no doubt about the case being one of anthrax. He subsequently, from certain symptoms, formed the opinion that there was internal infection as well as local. The anti-serum and also the carbolic injection were tried, but the case was too far advanced.

Dr. Eurich, in his evidence, generally corroborated that of Dr. Crocker, and said that in his opinion the man died from internal anthrax, which he probably contracted by swallowing a germ.

The jury returned a verdict to the effect that death was due to internal anthrax.

West Wales Sanatorium.

A MEETING of the West Wales branch of the National Society for the Prevention of Consumption was held at Carmarthen Guildhall on August 21st, Sir James Williams-Drummond, Bart., Edwinsford, Lord Lieutenant of Carmarthenshire, presiding.

It having been mentioned that there were hopes of getting a £500 contribution as originally proposed, from the Carmarthenshire County Council, Mr. J. C. Harford, Falcondale, Lampeter, stated that the Cardiganshire County Council had practically received leave from the Local Government Board to advance £250 to the promoters of the sanatorium, and it was hoped the other two counties in West Wales would follow Cardiganshire's example. Dr. Bowen Jones, Carmarthen, one of the Hon Secretaries, in presenting the Finance Committee's report, showed that the estimated funds desired totalled £4,015 12s. 5d., the funds in hand when the committee met being £2,165 14s. 8d. That left a deficit of £1,849 17s. 9d. to be arranged for at the next general meeting.

Mr. Wheldon, treasurer, National Provincial Bank, Carmarthen, said they had now £1,165 in hand, another instalment of £1,000 having been paid to the contractor. The commission of the architect had also been met. £1,040 had to be found for those officials in October. They had to find some £500 or £1,000 for furnishing the building, and then talk about the maintenance fund. They were face to face with a serious problem, but this might be overcome if they put their shoulders to the wheel.

The furnishing of and maintaining the sanatorium was discussed at great length, and £1000 was individually guaranteed in the room, viz., £500 by Sir James and Lady Drummond, £200 by Mr. and Mrs. Trubshaw, £200 by Colonel Davies-Evans, Highmead (Lord-Lieutenant of Cardiganshire), and £100 by Colonel Morris, Garnant.

A guarantee fund of £2,000 having been formally opened on the motion of the chairman, Sir James Drummond remarked that no doubt Earl Cawdor, Sir James Hills-Johnes and Lady Hills-Johnes, and Mrs. Johnes would also become guarantors. It was understood that it was merely a nominal thing, it being felt that the money would be forthcoming when appeals were made. It was decided to ask the chief subscribers also to become guarantors, and to ask the clergy and ministers in West Wales to have special collections in their churches and chapels.

Goldfeld Again.

In the City of London Court, on August 22nd, an action was brought by Aaron Goldfeld, a German, giving an address in Falcon Square, Aldersgate Street, against Mr. Marcus Gunn, of Harley Street, to recover damages for "negligence at operation." The counsel for the defendant said the matter was *res juaicata* and the Court had no jurisdiction. The defendant was a well-known ophthalmic surgeon, and the plaintiff, in the name of Schleifstein, came to Moorfields Hospital suffering from hemianopia. He was operated upon in 1896, and nothing more was seen of him until May, 1904, when he came back to the hospital as Aaron Collins suffering from a detached retina. That was incurable. The plaintiff had recently lost his sight. He had brought three actions against the defendant, one in the Whitechapel County Court, another in the Bloomsbury County Court, and a third in the Shoreditch County Court. In all three the Judge had decided in favour of the defendant. Now the plaintiff had brought another action, and until the Attorney-General came back from his holiday there was no power to stop him. The plaintiff made a long statement to the Court in which he said all he wanted was justice. He had been to the hospital 50 or 60 times, and had undergone eight operations. His sight had been thoroughly destroyed. He was put under cocaine, not chloroform, and therefore he knew exactly what was done. He had been treated like an animal, and now the sight of both eyes had been destroyed. Judge Lumley Smith, K.C., said he was sorry for the plaintiff but he had no power to try the action over again. If the plaintiff liked to ask the County Court Judge for a new trial he might do so. He did not advise such an application. All he could do was to strike out the case with costs.

Sewage-Fed Mosquitos.

There is a perfect plague of mosquitos at Stonebridge Park, Harlesden. Several well-known residents are under treatment for blood-poisoning, set up by bites from these insects. The adjacent Brent Sewage Farm, belonging to the Willesden District Council, is said to be the origin of the trouble.

National Association Sanatorium.

The first sanatorium of the National Association formed to establish and maintain sanatoria for workers suffering from tuberculosis is being rapidly erected.

The building will probably be ready for the reception of patients at the end of the year. The site of the sanatorium is at Benenden, Kent, and is 700ft. above the sea level. No fewer than 252 acres have been acquired by the association.

The primary purpose of the movement is to treat workers in the earlier stages of tuberculosis, when cure is still practicable, and special attention will be paid to members of friendly societies. Over 32,000 postal employés have consented to contribute from their wages a certain sum for the maintenance of the establishment. The Post Office Sanatoria Association undertakes to endow 25 beds, the Hospital Sunday Fund five, the Club and Institute Union two, the Royal Oak Benefit Society one, the Foresters (South London Branch) one, the Amalgamated Society of Railway Servants one, and the National Union of Teachers two.

The building is to be constructed on a novel plan, "Frazzi" tiles being used on steel supports, and no brickwork being employed.

The building is to be self-supporting, and economy will be practised in the outdoor work of the patients which is part of the new system.

Doctor's Tragic Death.

At Lambeth Coroner's Court on August 25th, an inquest was held on the body of Dr. Charles Eardley Dumbleton, formerly medical officer of Singapore, who was found dead at St. Thomas's Home. William Barnes Chamberlain, said that Dr. Dumbleton, who was about fifty years of age, had resided lately at the Hampden Club, St. Pancras. He was a visiting surgeon at a hospital for skin diseases. Recently Dr. Dumbleton entered St. Thomas's Home. He had never threatened suicide, but had been troubled with sleeplessness. Nurse Everett said that Dr. Dumbleton had been under her care since she had been on night duty. He was very restless on Tuesday night, and in the morning when she took in his breakfast she found that he was not in his bed. She was told by another patient that he was asleep in another room. She went there and found him dead. Dr. Hedley, the resident medical officer of the Home, stated that Dr. Dumbleton was suffering from a swelling of both wrists, which was due to gout. He was expected to be quite well again in a few weeks. He had restless nights and was given drugs to induce sleep There would be pain in the wrists but that was relieved by hot fomentations applied at frequent intervals. On Tuesday night he seemed more cheerful than usual. From a *post mortem* examination it was found that the doctor had had malaria several times. Asphyxia from strangulation was the cause of death. A verdict of suicide whilst temporarily insane was returned.

Death from Hydrophobia.

A man named Albin Boehm, the owner of an estate at Promontor, near Buda-Pesth, died on August 23rd, of hydrophobia. Four weeks ago, while playing with a small dog, Boehm was bitten in the hand. The wound healed, and he thought no more of it. On Sunday of last week Boehm became unwell, and the doctors ascribed his illness to the bite. They sent Boehm to the Pasteur Institute at Buda-Pesth, where the symptoms of rabies were recognised, and the patient duly inoculated. Boehm subsequently returned home, and informed his wife that he was irretrievably lost. Boehm's condition became so much worse that he was conducted again the next day, in the company of two policemen, to the Pasteur Institute, and the doctors certified that nothing could be done. The unhappy man declared that he would die at home, so, with two strong attendants, he returned to Promontor, where he was placed in a separate room in his house. Thus until Tuesday, Boehm could speak through the door to his family and friends. Towards nine o'clock in the evening he became very weak, so he took to his bed, A violent attack seized him and caused his death soon afterwards.

Plague Mortality in India.

The Chief Plague Officer of India, in his report for 1905 shows that the deaths from plague have progressively doubled in each of the last three years In 1903 the deaths were 80,729; in the following years they were 166,620, and in 1905 they had risen to 305,737. Of the total number recorded for the last mentioned year 281,020 occurred in villages and towns under 50,000 inhabitants, only 24,717 deaths being registered in towns of 50,000 inhabitants or over. An active campaign against rats was carried on during the last four or five months of the year, and the report suggests that this was not without effect in lessening the spread of the disease, but at the same time it is recognised that to destroy all the rats in the villages is practically impossible, and that evacuation of the infected spot is the only remedy once the disease has manifested itself.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS. ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT GYNÆCOLOGICAL LITERATURE.

The employment of Nitze's cystoscope when the bladder has been filled with air in the knee-chest-position is recommended for some conditions by Stoeckel (*Zentralbl. f. Gyn.*, No. 31, 1906). He says there are quite a number of cases in which the classical method of Nitze is not employable, especially when the bladder is defective (fistula) or incapable of holding the fluid injected to fill it, or too sensitive to allow of the injection of the fluid. Again where there is severe pyelitis the injected fluid rapidly becomes opaque if the pus escapes at all quickly from the ureter. For such cases his method is most valuable. It differs from the methods of Kelly and of Pawlik in that the Nitze cystoscope is used. The technique is difficult, the position of the patient uncomfortable, and there is danger of burning the wall of the bladder with the cystoscope lamp which rapidly becomes hot. Consequently the examiner must have had much experience in the use of the cystoscope before adopting this method. One can only recognise the urine from the ureters by the eddies it causes in the water-filled bladder, on the contrary when only air is present the thick stream itself shoots across the field of view as if it had been ejected from a syringe.

G.

The use of the rubber bag dilator in midwifery is reported on by Bürger (*Archiv. f. Gyn.*, Bd. lxxvii. Hft. 3) from observation of its employment in Schauta's Klinik. After describing the history of the development of the bag treatment, he gives a clear description of the mechanism of its action as it has already been demonstrated by others, especially von Bardeleben, and here, of course, its action is compared with that of the modern branched metallic dilators. The greatest service of the bag lies in its capability of being put to so many uses. It may not only be used for the induction of labour and strengthening of the uterine contractions, but also to prevent too early rupture of the bag of membranes, or as a substitute for the latter when it has already ruptured. It may thus be employed for the conduction of parturition without complications with the same advantages as when it is employed for accouchement forcé in eclampsia. Its use as a preventor of hæmorrhage in placenta prævia must also be remembered. Thus the bag has become a general friend to obstetricians, to which the simplicity of its technique has much conduced. The author then relates the good results obtained by Schauta. There are 147 cases which he describes in different groups according to the technique, which varies with the different indications for the use of the bag. The first class embraces those cases in which it was used before the onset of labour, the second when it was used after the onset of labour. In the first group there are sixteen cases of induction of labour and of abortion, in the majority of which other methods of induction had been tried in vain. To the second group belongs naturally the greatest number of cases, and among them particularly cases of eclampsia and placenta prævia. The statistics include 45 cases of eclampsia; 35 primiparæ, 10 multiparæ. In 21 cases there was not yet any appearance of labour, 31 cases had not come to full term, and 8 of the primiparæ were over 30 years of age. In 23 cases constant manual traction was applied to the bag. Incisions of the cervix were necessary in only 4 cases, and were made on account of its contraction about the after-coming head. In 4 cases the bag treatment failed. Regarding the question whether after insertion of the bag and the application of manual traction the fits were not increased, it may be mentioned that in 22 cases fits were still to be observed after labour was concluded, and that they were seen in only five cases during the action of the bag. Nine women out of the forty-five died. The puerperium of the survivors was free from fever in every case. The bag was used in 19 cases of placenta prævia. It must be reserved for the most difficult cases in which the dilatation of the os is not advanced enough for the employment of Braxton Hicks' version for fear of causing lacerations. Among 240 cases of placenta prævia Schauta's Klinik had 8 per cent. mortality. Among the 19 with bag treatment there were 3 deaths therefore more than 15 per cent. The author also cannot agree with Küstner and others that the bag treatment gives a lower infantile mortality. In placenta prævia the bag acts with greatest advantage at the commencement of labour as a preventor of hæmorrhage. In conclusion the author lays stress once more on the good qualities of the bag as a dilator, especially its physiological action as compared with metal dilators, and commends it as a most valuable help for general practitioners in difficult situations.

G.

Cervical lacerations in primiparæ. Scheurer (*Archiv. f. Gyn.*, Bd. lxxvii. Hft. 3) has examined the injuries to the cervix received during labour among newly delivered women and studied their ætiology. Ninety-nine primiparæ in the Frauenklinik Bern were examined by him soon after the expulsion of the placenta, and again when they were leaving the hospital. Following v. Bardeleben he divided the injuries into 4 groups. (1) complete lacerations of the cervix 13 cases; (2) large lacerations 13 cases; (3) moderate lacerations 46 cases; (4) notchings 27 cases. As regards the ætiology the most important cause is operative interference of every description. More than half the cases of complete laceration occurred in labours completed by operation. Abnormal presentations of the head are also an important causative factor. The average weight of the infants is in cases with severe lacerations more than 300 g. greater than in cases with small lacerations. Lacerations are also predisposed to by old age in primiparæ and by placenta prævia. The influence of premature rupture of the membranes and of contracted pelves could not be ascertained with certainty. The laceration is nearly always lateral, and in cases where there is one severe laceration or a more severe laceration on one side than the other, the right side is most frequently the one so affected. The relation between the position of the presenting part and the situation of the laceration could not be estimated. The largest lacerations were followed generally by little or no hæmorrhage. Whether there was any effect on the puerperal morbidity or the involution of the uterus could not be determined.

G.

Tuberculosis of the vulva according to Bonnin, Paris (*Zentralbl. f. Gyn*, No. 31, 1906), is usually secondary to genital or visceral tuberculosis. It may also be primary and may occur without infection of any other part of the generative system. The best known form is the ulcerative. The ulceration may be circumscribed, but it generally invades the larger and smaller labia, frequently also the perniæum and inner surface of the thigh. In addition to the ulcerative form there is another which is characterised by a pseudo-elephantiacal hypertrophy of the skin of the vulva without any ulceration. The microscope is necessary for the difficult diagnosis of this form. The prognosis is serious since the ulcerations always recur. It is especially grave in little girls

who frequently die of acute phthisis or secondary meningitis. The treatment of the ulcerative form consists in curettage and cauterisation, while the hypertrophic form must be extirpated.

G

The Causes of Sterility.—Ward (*Amer. Journal of Obst.*, August, 1906).—After referring to the low birth rate of America, Ward says that at the present day, with the attainment of the highest types of civilisation, we find, that instead of sterility being an opprobrium as in former years, it is often regarded as a boon by our fashionable women, but while voluntary "race suicide" is alarmingly prevalent, there is still that great multitude who, through no wish of their own, are childless, and spend their time and money in seeking relief. The sterility with which gynæcologists are specially concerned is that form which is attributable to some functional or organic defect in the woman which prevents child-bearing. There are four essential factors necessary to a conception: (1) the production of healthy spermatozoa; (2) the production of a healthy ovum; (3) the union of spermatozoa and ovum, and thus starting segmentation; (4) implantation of the fertilised ovum in the uterine mucosa. Various influences may temporarily suspend the function of ovulation. Debilitating or prolonged disease or a depressed state of the nervous system may be accompanied by amennorhœa and suppression of ovulation. The rheumatic or gouty diathesis, syphilis, alcoholism or drug addiction probably cause suppressed ovulation by reason of nutritive defects. The association of sterility with obesity is interesting, as there seems to be a direct relation between the ovarian function and fat formation; if the ovaries for any cause become functionally inactive or atrophied the woman is sterile and also obese. And Ward considers that the obesity is associated with the sterility as a result of the inactive ovaries, rather than the obesity being a cause of the sterility. Taking a broad view of the subject he does not consider flexions, displacements, neoplasms, &c., *per se*, as direct causes, but factors, and says if we look for the most common causes of endometritis and salpingo-oophoritis we will place our finger on the most prolific causes of acquired sterility. Gonorrhœa is the cause of perhaps 90 per cent. of the cases of septic salpingitis and of septic endometritis, and next to gonorrhœa he believes sepsis and subinvolution following abortion or labour are the important causes, especially of the so-called "one child" sterility. The cases of sterility associated with flexions, displacements, subinvolution, fibroids, &c., are due to not these conditions, *per se*, but to the associated chronic endometritis. In conclusion, we must be greatly impressed by the great importance of gonorrhœa in its relation to sterility when we remember it is nearly always responsible for sterility in the male, and as in nearly all instances of sterility in the woman due to gonorrhœa the infection has been innocently acquired by the wife from her husband, the fault lies with the man in more than two-thirds of all cases.

F.

Significance of Uterine Hæmorrhages of the Menopause.—Murray (*Amer. Jour. Obst.*, Aug., 1906). The author after revising the opinions of many writers asks the important questions:—Is an increased flow at the time of the menopause physiological? and is a hæmorrhage either that of menorrhagia or metrorrhagia merely functional and not a pathological condition? Duff in a paper on the subject reports the examination of 482 healthy women and only found 39 who gave a history of what could be termed hæmorrhage during the menopause, and only 5 gave a history of menorrhagia of any importance; Lockyer reports that out of 871 cases 662 gave no history of loss of blood and 208 had either menorrhagia, metrorrhagia, or a sanguineous discharge. Murray believes the normal change of life is established without an increased loss of blood, that the flow is less during the second decade of menstruation than the first, and less during the third than the second. At the period of cessation it decreases, coming slowly, less in amount of flow and less in the time occupied by the flow. In many cases the cessation of the menses has taken place without any intervals occurring between the regular times, but more frequently intervals of a month, two months, or more occur. The uterine hæmorrhages are often produced at the time by causes which obtain throughout the menstrual life of a woman, but which are more likely to give trouble when she is advanced in years or after frequent pregnancies or abortions—in fact this is the great reason why an excessive loss of blood has come to be considered concomitant with the menopause. Inflammatory conditions like cervicitis, endometritis, metritis, and the resulting hyperplasias come in this category, as do benign growths; polypi, fungoid endometritis, fibroids, fibroid infiltration, myofibrosis of the uterus, and diseases of the tubes and ovaries are conditions often found, and, lastly, hæmorrhage at this time is often a symptom of carcinoma.

F.

Typhoid Fever Occurring during Pregnancy.—Faulkrod (*Amer. Jour. of Obstetrics*, August. 1906). In recording observations of some cases of pregnancy complicated by typhoid fever, Faulkrod draws the following conclusions, without positively asserting them. The temperature records of the majority of cases are modified in some manner from those of typhoid not combined with pregnancy. Just as the mixed infection of typhoid and malaria may occur where the course of one or the other is modified during the height of the more toxic infection, so pregnancy and typhoid may be considered a mixed infection. After the growth and formation of the placenta, the blood of the mother generates in the serum-antibodies, which antagonise the invasion of syncytial tissue, and as the fœtus grows older the blood becomes more and more resistent to infection and we find the following to be true. In a typhoid infection occurring in a pregnant woman before the fourth month, the typhoid fever will prove the predominant infection, will develop a higher temperature than at a later date and the patient will, in as high as 85 per cent. of cases abort. The temperature and pulse, as a rule, fall at the inception of the pains and rise the day following delivery. In a typhoid infection occurring later than the sixth month the pregnancy will prove the stronger infection; the course of the typhoid will be modified greatly, and even at times so held in abeyance that the patients will not experience the slightest discomfort beyond the first symptoms of the infection. The temperature records prove of a flaccid weak type, the patients are relatively less toxic, and will usually carry the child to term. The question of the cause of abortion is interesting. No doubt, when the temperature ranges above 104° the fœtus or ovum cannot survive; also in fœtal infection it is right to suppose that perhaps the fœtus may die when the mother survives; but what causes the patient to abort after the temperature has reached normal and when, up to the day of abortion, she has appeared to be convalescing normally? The abortion must come from one of two sources: either the blood of the mother refuses to furnish food for the growing embryo, and also, as we above noted, furnish serum for antibodies, when already her cells are crowded with antityphoid serum, or again perhaps the antityphoid serum may also act as an antibody to the growing ovum; and second, is there not a possibility of some degeneration occurring in the endometrial tissue in a somewhat similar manner to the results of typhoid on the muscular and nervous tissue of other parts of the body, the uterus becoming not a fit ground for growth? Are we therefore led to believe that there is something generated by the pregnant woman which in a certain measure does protect her from the more virulent attack of the toxins of typhoid fever, and that the course of the fever is undoubtedly modified should it occur at such a period of pregnancy that the serum or cells have been charged with immunising bodies?

F.

NOTICES TO CORRESPONDENTS, &c.

CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to 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 proofs.

WITNESS.—You should not have accepted the 3s. without protest. By order of the Home Office "reasonable travelling expenses may be paid where the witness has to travel more than two miles to give evidence," though the "reasonableness" of the Home Office is generally third class.

ANTI-QUACKERY.—You compliment the laity too much in imagining there is any limit to their credulity. Only lately we met a lady who had paid 10s. 6d. for, and was wearing, an "anti-rheumatic" finger ring, and a sane, well-educated man carrying a potato in his pocket as a cure for sciatica.

AN ECHO OF THE RECENT CHRISTIAN SCIENCE TRIAL.

IT will be within the recollection of many of our readers that at the recent trial at the Old Bailey, in which Dr. Adcock was acquitted on a charge of malpractice, it was stated that the wound was dusted with ektogan. In view of the fatal result, not to mention the admitted sepsis of the sloughing bedsore, it seems only fair to state that ektogan, from its chemical composition, should be an excellent antiseptic preparation. It is a peroxide of zinc, containing about 10 per cent. active oxygen. The point is how it was used in Major White's case. Obviously it would be an absolute farce to sprinkle an antiseptic powder upon a large sloughing sore. The manufacturers are clearly entitled to protest against the injury that might result to their preparation without the added explanation.

DR. H. (Leeds).—Medical practitioners are required to notify to the Chief Inspector of Factories every case of mercurial poisoning contracted in a factory or workshop. A fee of 2s. 6d. is allowed for this. Dr. K. W. Goadby has written a good deal on the subject of lead anæmia, and all medical publishers keep a subject index to publications.

ANON (Chelsea).—We have applied our intelligence to the problem you set us, but are unable to solve it. Is it that we are obtuse, or is it that your argument is involved? Why not submit your idea to our readers' judgment?

PATENT MEDICINES AT THE CAPE.

Commenting on our recent exposures of patent medicine frauds and quackery in general, a subscriber at Cape Town, who is also a Member of the Cape of Good Hope House of Assembly, writes us that "ordinary inventions, such as the so-called 'patent medicines,' are protected here, as in England, for fourteen years only, but, in practice, the trade mark position of them means an indefinite monopoly. An effective remedy would be the limitation, or better still, the withdrawal altogether of this trade-mark protection." Our correspondent's letter contains other suggestions of considerable interest; he encloses also an official report of the "Select Committee on Quackery and Quack Medicines at the Cape," which we hope to deal with more fully in a subsequent number.

ET TU QUOQUE.—We will see what can be done in the matter. There is nothing unethical, as the letter with enclosure is sent to the profession only. It is however, a cheap way of getting an advertisement at the expense of a public institution.

J. O. H. S. will receive a private letter so soon as the necessary inquiries have been made.

LEGAL.—In most cases where a practice changes hands the purchaser takes over the vendor's house, either by way of purchase or by a lease for years. The conveyance is, however, drawn up in a separate document. You can get all information from *The Law of Medical Partnerships* (Barnard and Stocker).

Meetings of the Societies, Lectures, &c.

WEDNESDAY, AUGUST 29th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—10 a.m.: Diseases of the Throat, Nose, and Ear. Diseases of Children. 2 p.m.: Medical and Surgical Clinics. 2.30 p.m.: X Rays. Operations.

THURSDAY, AUGUST 30th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—2 p.m.: Medical and Surgical Clinics. 2.30 p.m.: X-Rays. Operations. Diseases of the Eye.

FRIDAY, AUGUST 31st.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—2 p.m.: Diseases of the Throat, Nose, and Ear. Medical and Surgical Clinics. 2.30 p.m.: X-Rays. Operations. Diseases of the Skin.

SATURDAY, SEPTEMBER 1st.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—10 a.m.: Diseases of the Throat, Nose, and Ear. 2 p.m. Medical and Surgical Clinics. 2.30 p.m.: X-Rays. Operations.

Vacancies.

York County Hospital.—House Physician, with board, residence, and washing. Salary £100 per annum Applications to Fredk. Neden, Secretary and Manager, York.

Egyptian Government.—Ministry of Education.—Professor of Midwifery and Gynæcology. Salary £400 a year, with private practice. Applications to the Director, School of Medicine, Cairo, Egypt.

Egyptian Government.—Ministry of Education.—Medical Tutor and Registrar to Kasr-El-Ainy Hospital. Salary £400 a year. No private practice. Applications to the Director, School of Medicine, Cairo, Egypt.

Manchester Hospital for Consumption and Diseases of the Throat and Chest.—Assistant Medical Officer for the new Crossley Sanatorium, Delamere Forest, Cheshire. Salary £100 per annum, with board, apartments, and laundry. Resident Medical Officer for the Hospital, Bowdon, Cheshire. Salary £100 per annum, with board, apartments, laundry. Applications to C. W. Hunt. Secretary, Hardman Street, Deansgate, Manchester.

Chesterfield and North Derbyshire Hospital and Dispensary.—Senior House Surgeon. Salary £120 per annum, with board, apartments and laundress. Applications to the Secretary at the Hospital.

Dorchester County Asylum. — Junior Assistant Medical Officer. Salary £140 per annum, with board, lodging, &c. Applications to the Medical Superintendent.

Walton Workhouse.—Resident Medical Officer. Salary £125 per annum, with board. Applications to Harris P. Cleaver, Union Clerk, Union Offices, Brougham Terrace, Liverpool.

City of Birmingham Asylum, Rubery Hill, near Birmingham.—Assistant Medical Officer. Salary £150 per annum, with furnished apartments, board, &c. Applications to the Medical Superintendent.

Grey Hospital, King William's Town, Colony of the Cape of Good Hope.—Resident House Surgeon. Salary £300 per annum. Applications to the Agent-General for the Colony, 100 Victoria Street, Westminster, London.

Warrington Union Workhouse.—Resident Medical Officer. Salary £130 per annum, with apartments, rations, and other usual allowances. Applications to J. C. Sutton, Clerk to the Guardians, Bewsey Chambers, Warrington.

Royal Southern Hospital, Liverpool. — Resident Pathologist and Registrar. Salary £100 per annum, with board and residence. Applications to the Chairman of the Medical Board.

York Dispensary.—Resident Medical Officer. Salary £120 a year, with board, lodging, and attendance. Applications to W. Draper Esq., De Grey House, York.

Appointments.

BECKETT, F. H., M.B., B.C.Cantab., Certifying Surgeon under the Factory and Workshop Act for the Ely District of the county of Cambridge.

EVANS, JOHN, M.B., B.S.Lond., M.R.C.S., L.R.C.P.Lond., Clinical Assistant to the Hospital for Consumption and Diseases of the Chest, Brompton.

SMYTH, RICHARD, M.D., M.Ch., M.A., T.C.D., Honorary Surgeon to the Ramsgate and St. Lawrence Dispensary.

Births.

HEALEY.—On Aug. 24th, at Ravenswood, Preston, the wife of Edridge Healey, M.B., of a daughter.

HOVENDEN.—On Aug. 25th, at Kitson Lodge, Barnes, the wife of Gerald S. Hovenden, M.D., B.S.(Lond.), M.R.C.S., of a son.

LISTER.—On Aug. 19th, at Terrington Lodge, King's Lynn, the wife of Septimus R. Lister, M.R.C.S., L.R.C.P., of a son.

MARSHALL.—On Aug. 20th, at Thorverton, Devon, the wife of C. de Z. Marshall, M.R.C.S., L.R.C.P., of a son.

MARTIN.—On Aug. 17th, at Blakau Mati, Singapore, the wife of Major Claude Buist Martin, R.A.M.C., of a daughter.

Marriages.

CHEYNEY—STUDDERT.—On Aug. 22nd, at St. Mary's Cathedral, Limerick, George Hammond Cheyney, M.R.C.S., L.R.C.P., son of the late Geo. J. Cheyney and Mrs. Cheyney, of Ware, Herts, to Gertrude Evelyn, third daughter of Mr. and Mrs. Jonas Studdert, of Kilkee, co. Clare, Ireland.

SIMKINS—SANDERS.—On Aug. 21st, at St. Mary's, Chigwell, William Almond, youngest son of the late Alfred Simkins, Carrington, Nottingham, to Ethel Mary, youngest daughter of the late Charles Sanders, M.D., and of Mrs. Sanders, The Haylands, Chigwell, Essex.

Deaths.

BRADDON.—On Aug. 23rd, at Troloss, Lanarkshire, John Vaudrey Braddon, B.A.Camb., J.P., of Leftwich House, Northwich, Cheshire, eldest son of the late C. H. Braddon, M.D., J.P., Cheetham Hill, Manchester.

CLIPPINGDALE.—On Aug. 23rd, at 50, Northfield Road, Stamford Hill, London, Rachel, widow of the late S. D. Clippingdale, surgeon, in her 88th year.

GIFFORD-BENNET.—On Aug. 21st, in London, Jane, widow of Dr. R. O. Gifford-Bennet, of Park Place, Buxton.

GRIMSHAW.—On Aug. 17th, at Friar's Hill, Wicklow, Elizabeth Dorothea, widow of Wrigley Grimshaw, Esq., F.R.C.S.I.

NAPPER.—On Aug. 22nd, at Broad Oak, Cranleigh, John Henry Napper, M.R.C.S., L.R.C.P., third surviving son of Albert Arthur Napper, surgeon, Cranleigh, in his 27th year.

ROUTH.—On Aug. 18th, at Springsure, Queensland, William Routh, M.R.C.S., L.R.C.P., only son of the late James Routh, of Wandsworth Common, S.W., in his 41st year.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIII. WEDNESDAY, SEPTEMBER 5, 1906. No. 10.

NOTES AND COMMENTS.

Enteric Fever in Camp.

THE deaths of three promising young officers in Fleetwood Militia Camp cannot fail to serve a useful purpose by calling attention to the whole question of Army typhoid prevention both at home and abroad. If the Army surgeons cannot keep barracks and camps free from so preventable a malady when dealing with it on a small scale, and under the simplest and best conditions, how can they be expected to cope with the disease in the hurry and stress of a campaign? Elsewhere in our present issue we comment on the field always open for the Army surgeon in the investigation of enteric fever in home commands. Certain camps and barracks are notoriously the chosen abode of endemic typhoid. Any well-trained civilian expert, given time and the necessary means, would consider himself disgraced did he not rid such depots of the malady within a reasonable period. Why should not the stigma of incompetence apply equally to Army surgeons if they fail in a similar way? Director-General Keogh has done much in the way of post-graduate instruction of Army surgeons. Doubtless he has carefully considered the advisability of regular recurrent courses of instruction in civilian sanitary work.

Summer Diarrhœa.

THE month of August has been marked by epidemics of summer diarrhœa in various parts of the Kingdom. One of the interesting points about the malady is its strongly marked local incidence. Among the places that are suffering most severely is Birmingham, where the returns for successive weeks from diarrhœa have shown 19, 47, 86, and 112 deaths respectively. These figures point to a serious outbreak, and the subject is not unnaturally attracting a good deal of attention on the part of the civic authorities. In London the diarrhœa deaths for the four weeks mentioned have been 184, 285, 424, and 458. In Manchester during the same period they have numbered 17, 34, 80, and 113. The rapid increase has followed the usual rise in earth temperature, but this year the phenomenal heat is doubtless related closely to the increased severity. It seems somewhat curious that medical science, which has been in possession of so many data for so long a time, should summer after summer be compelled to fold its hands and gaze impotently upon a wholesale slaughter of our infantile population. Perhaps we have not secured sufficient data for generalisation in the framing of preventive measures. Anyway the continuance of the scourge is a reproach to practical hygiene.

Its Causes and its Remedies.

IT would be difficult to name a disease with more marked characteristics than this bane of the summer season. The first great fact is that it is essentially a disease of towns. Arguing from that point, Dr F. J. Waldo some years ago insisted that the disease was mainly due to the peculiar qualities of town dust, charged with bowel bacteria of the horse and other animals. That the disease is intimately connected with food contamination is generally admitted. Milk being the staple food of children, and being further specially liable to pollution of manifold kinds in the course of collection, distribution, and consumption, is naturally the most suspected agent. In many quarters the house-fly is held to be responsible for a deal of the damage. Possibly to the investigator one of the most reassuring and encouraging of all facts connected with summer diarrhœa is the practical immunity of breast-fed children. The irresistible inference is that the malady is conveyed by foodstuffs other than that supplied by Nature. To get rid of the disease means to purify effectually the air of towns and to educate the community generally as to the necessity of domestic hygiene and of scrupulous care in the storage and preparation of food.

The Irish University Question.

DURING the past fortnight the flow of letters on this subject has by no means diminished, but very little fresh light has been thrown upon it. The most important feature is perhaps the appearance of an increasing number of letters from Roman Catholics expressing a desire to see a re-casting of Trinity College. Amongst these may be mentioned two letters from members of the medical profession—Mr. Tobin, Surgeon to St. Vincent's Hospital, and Dr. Edward Magennis, M.D., R.U.I. Mr. Tobin is a retired member of the Army Medical Service, and at one time filled the post of Assistant Professor of Surgery in the Army Medical School. He expresses it as his opinion and as the result of his experience, whilst connected with the Army, that mutual intercourse, interests, and occupations, such as mixed education affords, are of value in forming

men's characters, and that it is right to give this fact due consideration before hastily condemning the so-called Trinity College scheme. Mr. Tobin re-echoes what we have already urged. Dr. Magennis' letter is written from the standpoint of a Catholic parent, who is anxious for a speedy, efficient, and equitable settlement of this vital question. He points out that no one can afford to despise the assets of Trinity College—its site, its buildings, and its world-wide traditions of learning. This suggests an interesting point. We objected to two universities because they would perpetuate strife. Even if it were possible to start the new on equal terms with the old this would be so, how much more will it be the case when the new is always conscious of an inferiority in prestige to its older rival. Another letter from a medical man—Dr. Laffan, of Cashel—appears in the daily press of Saturday last. It is, however, so intemperate in tone as to be far more injurious to the cause it would support than to that it would oppose.

LEADING ARTICLE.

IMPERIAL CANCER RESEARCH.

ANOTHER year's work of the Imperial Cancer Research Fund has gone by, and it is significant to notice how progress from the financial side is by no means commensurate with that on the scientific. The Cancer Research Fund is an undertaking the like of which has never been entered on before, in this country at all events, for it is the result of an attempt to endow purely scientific work sufficiently handsomely to allow no material objection to stand in the way of the best men being employed and the best work accomplished. And this without any directly utilitarian result being promised. Of course, a utilitarian object there is, and the work itself is eminently purposeful, but it would be mere charlatanry to inform the public that the prevention and cure of cancer would flow certainly and directly from the work of the Fund. The appeal for money should rest on the well-grounded hope that sound co-ordinated, scientific work will bring forth fruit in due time and on this ground only should subscriptions be solicited. It is sad, then, to notice from the report of the Fund that an appeal to the reason no less than to the imagination, of one's fellow-, countrymen, an appeal, too, for a comparatively modest sum, makes so little impression that the committee, in the fourth year of their existence, have been obliged to live partly on capital. A hundred and thirty thousand pounds was the sum the committee aimed at obtaining for a permanent endowment of the Fund, and some £80,000 was all they got originally, but with it they determined to start operations, hoping that new donors and subscribers would come forward. So, indeed, they have, for thirty-six new contributors have been found, but, on the other hand, no less than seventy-one old contributors have fallen out and the income of the Fund has suffered to the extent of more than £800. Taking into account the magnitude of the task the Fund has before it these numbers and these sums seem pitiably insufficient, and we still hope that the treasurer and the executive committee will see their way to "tap" the public pocket in some decisive and effective fashion. The number of people who realise that there is such a fund doing such work and needing money so badly, must be infinitesimal, and a judiciously-engineered campaign should certainly have a lasting effect on the prosperity of the Fund, especially if care were taken not to let the first flush of enthusiasm give way too rapidly to the apathy which is always likely to succeed it. It can well be impressed on the public that the researches carried on must necessarily be slow and arduous; in fact, at present, it may be said that little more than the establishment of the machinery and the clearing of the ground have been accomplished. The experimental investigations have all been directed so far to the ascertainment of quite elementary facts, such as whether malignant disease does exist in animals, and if its transference from animal to animal, and from man to animal, can be accomplished. Laborious as this task has been, far longer and more laborious ones have either recently been entered upon or still lie before the investigators. For instance, they have only just succeeded in obtaining offspring from mice suffering from cancer, a result which has taken three years to accomplish, and which is but a preliminary to the study of hereditary susceptibility. So, too, it took four years, and the examination of 100,000 mice to discover the occurrence of twenty-eight cases of spontaneous carcinoma of the mamma. One curious fact already ascertained by the work of the Fund is the extraordinary variability of the growth of transplanted carcinomas in mice, and if this be compared with the well-known clinical variations in the growth of cancerous tumours in man it is readily apparent that the key to the position may lie in research into the factors that contribute to this variability. Indeed, the task is already in hand, and attempts to modify the growth of tumours have been undertaken, and immunity in mice to inoculated tumours has been obtained by previous inoculation and by the injection of healthy blood. Altogether, it may be said that the prospects of substantial advance are brighter than they have ever been, and that if the public will only support the Fund with sufficient generosity a day of great things may be at hand.

NOTES ON CURRENT TOPICS.

American Spelling Again.

THE President of the United States and with him the spelling "Reform" Committee, whatever that may be, appear to have somewhat over-reached themselves. This masterful attempt to enforce new methods has been unanimously repudiated by the public press throughout the American continent. Spelling "reform" mania, however, is no new matter to the MEDICAL PRESS AND

Circular. Several years ago we first entered our protest against it, when certain practitioners of "Filadelfia," began to "reform" the spelling of medical terms. In this connection it is of especial interest to learn how obnoxious to the American educated public the clipping and lopping of English words generally has proved to be; indeed so much hostile feeling has been excited throughout the United States by the President's promulgation "ordering" these "reforms" that, in the opinion of the best authorities, nothing will be done. The public Press in the United States is entirely free and independent, and will not be "ordered" by anyone, not even by the President of the Republic. We could only wish that the great medical publishing houses of America would exhibit the same freedom and independence, and insist upon the editors of the journals that they control and the authors of the books which they publish adhering to the common usages of spelling which belong to the English language. Then their journals and books would soon become more popular in this country, and be more sought after by English medical men. Meanwhile, everyone who is interested in this subject will closely watch the progress of the opposition to the President's ukase. Possibly, however, the President now feels sorry that he ever took the matter up, and Mr. Carnegie is possibly sorry also that he diverted some of his funds from founding public libraries to trying to make all the books thereof obsolete.

Experiments on Patients.

The public have a just horror of being "experimented upon" when they are ill, and were they not fed with malignant misrepresentations by certain people who, having a weak case, find refuge in the time-honoured dodge of abusing the plaintiff's attorney, they would be satisfied by the assurance that in Great Britain the light of public opinion and, let us add the good feeling of the medical profession, make any "experiment" impossible. That is, "experiment" in the sense in which they use it, for every dose that is prescribed for every patient is an experiment, and it is obvious that the science of medicine could not advance if new drugs and new treatments were not tried. The whole point about an experiment on a patient is whether it has origin in a well-grounded belief that it not only will do the patient good, but that it offers him the best hope of relief. It appears that in Austria a certain number of men have been experimenting with Rontgen rays in various conditions, and Röntgen rays are now known not to be so free from risk as they were originally believed to be. Consequently, if we may believe reports to hand, a certain number of unfortunate results have occurred and public feeling has been aroused. The Austrian Minister of the Interior has therefore issued an order that hospital doctors are not to make scientific experiments on patients or to treat them with remedies the efficacy of which has not been tested. Exception, however, is made in favour of experiments involving questions of diagnosis, immunisation, and prophylaxis, so long as these are carried out in deference to the departmental heads and have bearing on patients' actual complaints. Antivivisectionists will please note that in this country, while it is rightly held to be inhuman to experiment on patients, it is regarded as necessary to test new procedures and new drugs on animals before applying them to man.

The Surgery of the Broken Neck.

The marvels of modern surgery have been once more impressed on the British public in the rescue of Mr. St. John Harmsworth from what is popularly known as a "broken neck." by the exposure, and rectification of a fractured sixth cervical vertebra. We congratulate both the patient and his friends heartily on this most gratifying result. At the same time medical men will not fail to recognise that the surgeon's part in the incident is mainly mechanical. Large fees are not grudged to the operative surgeon, but the physician has to be content with a guinea or two for a consultation before handing over his patient for operation. Yet it is the patient physician who by localising the functions of the brain and spinal cord has shown the surgeon what is wanted. The work of the physician from an intellectual standpoint is incomparably higher than that of the mere operative surgeon. Now and then, of course, a giant like Lister arises amongst the surgeons and makes advances that are registered in the annals of all succeeding ages, but he does it as a man of general science rather than as a surgeon. To a great extent the field of the consulting physician has been so encroached upon that he will probably have sooner or later to emerge in a new form, possibly as a compound surgeon-physician. Thus in the far future we may revert to the original conception of the medical man who is competent in all the wide branches of his profession.

Is Appendicitis on the Increase?

Human nature is given to gregarious action in its joys, its sorrows, its fashions, but most of all perhaps in its fears. No one has ever been able to say exactly why a crowd, for instance, should be suddenly swayed to derision, or laughter, or fierce anger, or wild panic. At the present moment the British public is settling down after a wild wave of popular resentment against American tinned goods. But some of our national fears, if less obtrusive are none the less real and persistent Take the case of appendicitis, a disease that was hardly recognised a dozen years ago. It is pretty safe to assert that few grown and sane citizens of the Empire have not had the fear of appendicitis at some time flit across their mental horizon. It is therefore to be desired that all medical utterances upon the subject should be guarded and accurate. Only the other day the statement ran the round of the newspaper press that of late appendicitis had largely multiplied and in proof thereof was cited the steady increase of deaths

from that disease in one of the largest London hospitals. As a matter of fact, the malady is every year more accurately diagnosed and consequently more operations take place. In former years cases of the kind, not being then recognised, were ascribed to cold, inflammation, and other more or less vague causes. As a matter of fact, there is nothing to show that appendicitis is on the increase but a good deal to prove that a vast proportion of cases are curable if detected by the surgeon in good time.

Science as Moloch.

THE report of the wonderfully successful experiments of Dr. Alexis Carrell in the transplantation of the kidneys of animals has stirred the anti-vivisectionist professional writers into a state of indignation, and a good many articles have been let off on the subject. It is possible to take these writers too seriously, for they so obviously write to their brief that we guess most of their own supporters do not find their faith much strengthened by the stuff provided for them. An average sample of the argument provided in writings of this kind is to be found in a leading article in the *Morning Leader* for August 27th, entitled "The Moloch of Science." It begins by reciting the horrors of priestly tyranny over men's minds in earlier civilisations, and then goes on to point out how modern Europe has long been under the iron heel of medical tyranny, examples of which are found in laws to cleanse oysters' beards, and not to eat too much asparagus. We confess that we know little about the former, so that we fear either to endorse or to contradict this important injunction, but we should have thought medical teaching was not needed to let a man know that to eat too much of anything was not good. After these striking examples of the awful tyranny the public are subjected to, the writer proceeds to dwell upon the grim and foul superstitions which found vent in Dr. Carrell's experiments. The only conceivable excuses for the mutilation of helpless animals would be a plea that human suffering would be alleviated thereby, and Dr. Carrell and his associates have no such plea to offer. Is it demanding too much of the capacity of a writer of this type to ask him to follow the argument that if kidneys can be successfully transplanted from animal to animal it may be found possible to do so from animal to man? And that chronic nephritis is an incurable disease? A man who cannot take so small a step in reasoning for himself, and yet writes of "sheer wanton cruelty no shambles can offer any parallel to," makes one fear that the tyranny the future has to beware of is that of irresponsible scribes with more sail than ballast.

The Hatlessness of Womankind.

IN the earlier days of the fashion for hatlessness that recently overcame a small section of our womankind a country vicar banned the practice from his pulpit, and forbade any women to attend his church without a hat. His gospel has been adopted by the Vicar of Clewer St. Stephens, who recently announced his opinion that it was a disgraceful and abominable practice for women to appear in public without their hats. "Was it comely, he asked, for them to appear hatless in the public streets, or did it look modest? Did it not rather look bold and brazen?" Has the worthy vicar, we wonder, analysed the situation? Surely it is no worse for a woman to sit in church with her head bare than it is for a man. Infinitely better, moreover, that she should be hatless than clad in the average extravagant, gorgeous, and often inappropriate and inartistic millinery of to-day, possibly not paid for, to boot. In the theatre mankind with one accord condemns the selfish, vulgar, and stage-eclipsing feminine hat. Why should that which is rejected in the playhouse be sanctified in the church? From a scientific point of view most medical authorities would probably give their unhesitating support to the hatless-ones so lustily abhorred by the Vicar of Clewer St. Stephens. But let him take heart of grace, the feminine hat is far too gorgeous and important an article of dress to be abandoned for any length of time, especially before large congregations of one's fellow creatures.

"Minor Doctors."

ONE of the drug trade journals has been enlivening the "silly season" by advocating the establishment of a new order of practitioners under the above title. Basing its remarks on the fact that at the present time a considerable amount of medical practice is done by chemists and other unqualified persons, our contemporary suggests that these free lances should be given a legal status as practitioners for the relief of minor ailments. It is suggested that the standing of "minor doctor," doubtless with the title of M.D., should be attainable by passing an examination after a curriculum comprising one year of hospital practice and another of "minor medicine and surgery." We presume that the latter terms mean the sort of medicine and surgery that may be practised without any knowledge of the patient's condition, since it is suggested that "to visit patients must be penal," whether to the patient or to the "minor doctor" we are left to guess. Some such idea as this is said to have been foreshadowed years ago by Sir Benjamin Richardson, who suggested it as a mode of relief for the overcrowding of the profession. It is quite possible that the present standard required for qualification as a medical man is too high; it is certain that it could be improved without making it more severe. But the establishment of an inferior order of practitioner is not the way out of the difficulty.

Army Medical Reform and Enteric Fever.

THE breakdown of the Army Medical Department in South Africa showed us where a good many of the defects lay. On the other hand the absolute success of the Japanese in the medical administration of their recent campaign proved what is possible to scientific organisation. British

troops were decimated with enteric fever in one continent, while Japanese armies escaped scot-free in another. The fact of the matter seems to be that the British Army officer wants a complete education in practical hygiene. If Mr. Haldane be in earnest about Army reform, and intends to take the medical bull by the horns, let him first consider the question of camp hygiene. Enteric fever is never absent from our great military depots. Let the Army surgeons go down in batches and investigate, and let prizes and seniority be influenced by results. At present Fleetwood militia camp is being visited by an outbreak amongst the officers. The cause is still obscure, but it affords a fine field for exercising the faculties of budding Army surgeons. The minute investigation of a particular outbreak is worth a years' instruction in the class room. We believe the outbreak at Salisbury Plain depot some years ago was never satisfactorily accounted for. Yet we complain that our Army medical officers are unable to cope with the best understood and most preventable of all water-borne diseases in the field. As to India barracks and cantonments they are riddled with ever-present enteric fever, to the standing disgrace of our Army administration.

Old Highland Whiskey Again.

As might have been foreseen the Islington Borough Council does not intend to let the whiskey question drop. Not long ago their Inspector obtained a summons against a dealer for selling as "Old Highland Scotch Whiskey" an article found to contain 90 per cent. of patent (or silent or neutral) spirit, and 10 per cent. of pot still whiskey. The summons was dismissed on a technical ground, and on the inspector trying to a get a second sample he was served with a bottle having the label, "This is sold as a mixture of patent and pot still whiskey." He has now applied for a summons under the Merchandise Marks Act for selling the original sample with a misdescription. Clearly, consumers are entitled to have what they pay for, whether bought from a grocer or a publican, or any other tradesman. The gratitude of the community is due to the Islington Council for their public-spirited attitude in this matter.

Exfoliative Dermatitis in a Workhouse.

An epidemic of a serious skin affection has been reported from the Sulcoates Workhouse, Hull. Towards the end of last week some 80 patients were isolated, but the disease is still spreading. Some of those affected are said to be in a serious condition, and the matter has been reported to the Local Government Board. There can be little doubt from the scanty reports so far available that the epidemic is one of exfoliative dermatitis of the kind brought into prominence some years ago by the clinical observations of Dr. T. D. Savill. The etiology of the affection has never been absolutely demonstrated, but it appears reasonable to assume that the dermatitis is of toxic origin, and that either toxint or pathogenic organisms are conveyed by some agency common to the infected community, in most instances probably or possibly, milk. It has been further pertinently suggested that the desquamation which is so highly characteristic of the malady is the direct result of excretory damage or irritation to the skin, in the attempt to throw off some injurious product from the circulation. It is to be hoped that Dr. Savill will have an opportunity of investigating the Sulcoates outbreak.

PERSONAL.

His Majesty the King has conferred the decoration of the Royal Red Cross on Miss R. A. Betty, Senior Lady Superintendent of Queen Alexandra's Military Nursing Service for India, in recognition of her special devotion and competency during her long service in the Nursing Service in India.

Dr. Frances Harper, of London, has been appointed lady assistant medical officer at St. Helens. She is to educate midwives, teach women at mothers' meetings and give instruction in day schools and to women teachers.

Dr. Francis B. Rutter has been appointed a Country Magistrate for Wiltshire.

According to the will of Professor Tarnowski, the Russian dermatologist, his estate is to be devoted to establishing a hospital for invalid doctors.

Dr. John Hutchinson, of Claybrook, has received the grant for successful vaccination for the twelfth time.

Lieut.-Col. R. W. Ford, D.S.O., Deputy Surgeon of the Royal Hospital, Chelsea, has been selected for service at Gibraltar about the end of next month.

Major A. R. Aldridge has been appointed sanitary officer, Indian Army Headquarters.

On August 23rd King Leopold received Sir Alfred Jones and the representatives of the Liverpool School of Tropical Medicine, and expressed his gratification at the results achieved in combating sleeping sickness. His Majesty afterwards decorated Professors Boyce, Rice, and Todd.

Lieut.-Col. Coutts has vacated the appointment of Staff Officer to the Principal Medical Officer, Southern Command, and Lieut.-Col. R. W. Ford, D.S.O., has joined the London District for duty.

Major J. Thomson has assumed medical charge of Military Families Hospital at Woolwich, vice Lieut.-Col. R. J. C. Cottell.

A new London ambulance service has just been inaugurated, and will probably be in working order within the next few months. There will be two central stations, Bishopsgate Street and St. Bartholomew's Hospital, where the ambulances will be housed; and there will be nearly 50 sub-stations, similar to the existing fire alarms. The Post Office has received the order to instal them and to fix the necessary wires to connect them with headquarters. Two electric motor ambulances will probably be used, but only one has so far been ordered. It is to cost between £500 and £600. The Ambulance Committee, however, does not quite approve of the electric ambulance, as certain street corners in the City are difficult to turn.

A woman at Desborough, Northamptonshire, has died from spotted fever, a doctor having certified the cause of death.

A CLINICAL LECTURE
ON
THE DIAGNOSIS AND TREATMENT OF RINGWORM.

By G. NORMAN MEACHEN, M.D., B.S.Lond., M.R.C.P.Lond and Ed.
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Of all the common skin disorders which we are called upon to treat, few, perhaps, are so irksome or interfere so much with school or domestic arrangements as common ringworm, especially when this affects the scalp. Some idea of its prevalence may be gathered from the fact that out of 1,695 new cases admitted to the skin department of the Tottenham Hospital in 1905, ringworm was responsible for 201. Of these the scalp was affected in 174; the remaining 27 presented the disease in various other parts of the body. The youngest patient was one month old and the oldest 48 years; both these were cases of ringworm of the body (Tinea circinata). Ringworm of the scalp (Tinea tonsurans) is very rare in the adult; I myself have only seen one case. Aldersmith, with his extensive experience, has seen but six cases in twenty years.

Clinically, we may speak of five main varieties of the disease:—

1. Tinea tonsurans, or scalp ringworm.
2. Tinea circinata, or body ringworm.
3. Tinea barbæ, or ringworm of the beard.
4. The so-called eczema marginatum.
5. Onychomycosis, or ringworm of the nails.

1. Ringworm of the scalp, formerly known as Porrigo scutulata (Willan and Bateman), or "scalled head," is not altogether a happy phrase, for it is not at all necessary for the lesion to be circular in shape. Many years ago Dr. Robert E. Brown attempted to show that the growth and progress of the disease was analogous to that of the "fairy rings" of darker grass seen in meadows. It was thought that those cutaneous fungi which we now know to be the cause of ringworm resembled certain creeping plants which extend themselves beneath the soil in both lateral and radial directions. Many cases, however, exhibit no trace whatever of any ring formation, and it is then that difficulties of diagnosis are apt to arise. Like most morbid conditions, its first appearances may be completely overlooked, the child being thought by its parents to be suffering merely from a little scurfiness. Not until a definite bald patch is observed is any serious attention given to the head. The longer it is left to go untreated the more difficult is it to eradicate. The most obvious thing about the typical ringworm patch is the presence of the characteristic "stumpy" hairs. If these be really seen, either with the naked eye or with the aid of a magnifying lens, there can be no doubt whatever about the diagnosis. The diseased hairs themselves are worthy of a careful study. On minute inspection they are seen to be bent in all directions, some being inclined one way and some another. They are nearly always thickened at their point of emergence from the scalp, while their free extremities may end abruptly or may taper off to a point. The general appearance of the stumps has been well likened to "stubble in a cornfield" or to "bent fingers." Sometimes they look as if they had been nibbled by a mouse. They may be very numerous, or, on the other hand, only one or two may be found after much prolonged searching. The base of the patch is nearly always somewhat scaly, and it feels rough to the touch.

Since the discovery in 1843 of the tricophyton fungus by Grüby and Malmsten, and their further elaboration by Sabouraud and Rosenbach (1892-4), we have had at our disposal an absolutely scientific method of detecting the presence of tinea of the scalp, or, indeed, of any other part of the body. There are two main types of fungus (1) the *Microsporon Audouini*, or the small-spored variety; (2) the *Tricophyton megalosporon*, or the large-spored species, *endothrix* or *ectothrix*, according as the fungus lies inside or outside the hair. Small-spored ringworm forms at least 90 per cent, of all the cases of tinea tonsurans seen in this country. The geographical distribution of the two varieties is somewhat peculiar, for the microsporon is only responsible for 60 to 70 per cent. of ringworm cases in Paris, while in Italy it is practically unknown. The arrangement of the mycelium and spores as seen under the microscope also differs in the two species, that of the small-spored fungus being in the form of a mosaic which forms a sort of sheath upon and around the hair-shaft, that of the large-spored being in more or less regular chains or rows parallel with the hair. Cultures of the two fungi upon maltose-agar show characteristic differences, and in doubtful cases may assist the diagnosis materially. If there be the slightest uncertainty the microscope should always be employed, the rapid or potash method of examination being quite sufficient in the vast majority of cases for arriving at a correct decision. For this purpose two or three stumps or suspicious-looking hairs are epilated with forceps, mounted in a drop of the B P. liquor potassæ, and examined with a one-sixth objective. After a few minutes' interval the specimen will have "cleared" and the mycelial network and spores can then be made out. It is important not to confound the spores with minute droplets of fat separated by the alkali. If it be desired to make a permanent specimen the hairs can be stained with aniline-gentian-violet by Gram's method, time being given for complete decolorisation of the hair.

The plan of mopping the ringworm patch with a little chloroform is sometimes a useful one for rendering the diseased hairs more prominent, for after the evaporation of the chloroform the stumps assume a "mealy whiteness," as Allan Jamieson says. Even after considerable experience it is not always easy to be certain that a suspicious area upon the scalp is due to tinea. There are so many pitfalls into which the unwary may slip.

In the first place scaliness may be present to such a marked degree that the case is liable to be mistaken for a simple pityriasis or a seborrhœa capitis. This condition is seldom found in patches

but is generally diffused all over the scalp. The stumps may be very few and far between. In such a case, the best plan is to take a surface scraping of the scaly area and examine this in potash under the microscope for mycelium.

If there be much crusting, as in neglected cases, the condition may easily pass for a simple impetigo, but it should be remembered that under the most innocent-looking crust may lurk one or two hairs affected with tinea. It is, of course, possible for impetigo contagiosa to exist side by side with ringworm or to be engrafted thereupon. The sensation of touch is most useful in scalp affections, for there is a special roughness of the ringworm patch which can easily be appreciated by the sensitive finger-tips, quite unlike the peculiar "rocky feel" met with in ordinary impetigo. If crusting prevails upon one part of the scalp and the case is really one of tinea, it is more than probable that other areas near by will not be crusted over and, therefore, able to be felt by this means. I need hardly emphasise the importance of carefully examining the entire scalp, both with the fingers and with the hand-lens. I well remember seeing a little girl with what I thought was typical impetigo at the back of the neck associated, as is usually the case in this part of the body, with pediculosis. Being rather hurried at the time I was about to dismiss the case when I asked the child to take off her hat. I then saw upon the vertex of the scalp a large patch of ringworm which was not mentioned by her mother!

Inflammatory reaction may be the most conspicuous clinical feature, the diseased area being raised, reddened, boggy, fluctuating, and, perhaps, exuding pus from numerous small openings. This condition is known as kerion. Occasionally, this state of affairs manifests itself spontaneously, but more frequently it is the result of over stimulation of the patch, as with an ointment that is too strong. I have previously reported (*a*) a most instructive case in which kerion was found beneath an impetigo after a week's interval. The child was æt. 11, and on a first examination I failed to find any trace of fungus. At the next visit my search was successful, the *megalosporon endothrix* being found. If ever there was a case resembling impetigo, this was one.

Again, the patch may have such a smooth base as to simulate alopecia areata. The characteristic stumps are not seen and scaliness is absent. This condition, known as tinea decalvans, or "black-dot" ringworm (Aldersmith), or "bald" ringworm (Liveing), is associated with the large-spored fungus. On close inspection, the smooth area presents here and there small black dots, which are the tops of the hairs showing at the mouths of their follicles. These are with difficulty extracted by the ordinary epilation forceps, but may be obtained by using a comedo extractor. In ordinary alopecia areata we should not see these black dots, but instead the peculiar club-shaped or "point-of-exclamation" hairs which are never found in tinea tonsurans. It is important not to mistake the one for the other as the prognosis and treatment are essentially different.

2. Tinea circinata, or ringworm of non-hairy parts, nearly always presents itself in the form of small, well-defined patches in which involution has taken place at the centre. They are very common on the face and forehead of school-children, who are promptly sent home by their alarmed teacher. It often happens, however, that the so-called "ringworm" turns out to be nothing more than a simple patch of squamous eczema. I have previously shown here a little boy who came to the hospital with the story that he was "covered with ringworms," but on examination the lesions were seen to be those of eczema. The mother had fondly smeared them over with ink in the hope of curing the supposed ringworm quickly. The only satisfactory method of diagnosis is the examination of a surface scraping mounted in potash solution. The characteristic branching and jointed threads of mycelium will be found if the case is one of tinea circinata.

When the lesions are very small and scattered about the trunk some confusion is apt to arise with pityriasis rosea. Most British dermatologists have failed to find any trace of fungus in the latter disease, and consider it to be a separate morbid entity, though the Vienna school has long held the view that it is due to a fungus. A unique case was shown by Dr. Graham Little before a recent meeting of the Dermatological Society of Great Britain and Ireland, (*a*) in which pityriasis rosea was combined with tinea circinata in a boy æt. 10, the two diseases existing side by side.

It would not be supposed that tertiary syphilis could be mistaken for this variety of tinea or *vice versâ*, but I exhibited a case before the same Society (*b*) of a woman, æt. 35, who was transferred to me from the eye department of this hospital by my colleague, Mr. R. Philip Brooks, for an eruption of the face and lip, the eyelids also being affected, From the right external canthus there extended a trident-shaped, reddened elevation, accompanied with blepharitis. She also had a patch of similar appearance, circinate and slightly scaly, on the left side of the upper lip. This latter patch strongly suggested a tertiary syphilitic eruption. However, surface-scrapings revealed the presence of a tricophyton with a very fine branching mycelium. The condition had lasted for nearly three weeks. Sometimes the lesions, especially upon the lips, are quite pustular in character, suggesting at first sight a patch of eczema. Itching is much more severe, as a rule, than in the latter affection, and the fungus can be obtained in the surface-scrapings.

3. Tinea barbæ, or hyphogenic sycosis, is a common enough affection of the beard and moustache region, especially when the minor operation of shaving is not conducted upon strictly antiseptic principles. It has recently produced a little flutter of excitement in the law-courts, but it should be remembered that the barber's implements are not always at fault. The common grey coccus which inhabits the upper layers of the epidermis has been proved to be capable, under certain circumstances, of taking on a virulent form, so that it is quite possible for a patient to become infected from his own skin through a minute abrasion inflicted by a perfectly sterile razor.

Hyphogenic sycosis may generally be distinguished from the coccigenic variety by having fewer, if any, pustular lesions and by being more lumpy, swollen and infiltrated. The hairs may be pulled out easily and the fungus can be seen microscopically. Syphilis, that "rare imitator," may occasionally simulate ringworm of the beard.

(*a*) MEDICAL PRESS AND CIRCULAR, 1903 ii., p. 194.

(*a*) *Brit. Journ. Derm.*, vol xviii., p 184.
(*b*) *Ibid.*, vol. xvii, p. 185.

I have described the case of a coachman, æt. 50 (*c*), who complained of a sore lip, and in whom there was every appearance, clinically, of a lumpy sycosis. No fungus could be found on examination, and he had, in addition, an infiltrated patch on the arm, which, of course, cleared up the diagnosis.

4. The so-called "eczema marginatum" is only a clinical appellation for that variety of ringworm attacking the groins and axillæ. It is identical with the Dhobie itch of the tropics. When found in the perineal region it more commonly spreads downwards on to the thighs and very rarely mounts upwards to the abdomen. Owing to the heat and moisture of the affected parts it seems to be much more resistent to treatment than tinea circinata; it is certainly more common in private than in hospital practice. The margins are always abrupt, the general tint of the lesion is rather darker, as a rule, than is seen in tinea circinata, and the irritation is intense. It resembles somewhat a seborrhœic eczema, but the patch does not weep, and mycelium can be found in the surface-scrapings.

5. Ringworm affecting the nails only, or onychomycosis, is not very common, but it is very troublesome. The finger-nails are usually attacked, and they gradually become brittle and of a greyish-yellow tint. When the whole nail-plate is involved the free edge may show an accumulation of epithelial *débris*. The diagnosis is rendered complete by examining scrapings from the nail in potash, but the fungus is sometimes very difficult to find. Without the microscope it is almost impossible to distinguish this condition from psoriasis of the nails.

The question of treatment may be prefaced by saying that accurate diagnosis is absolutely essential, and that ringworm of the body is much more easily cured than that of the hairy scalp.

It was a favourite dictum of Tilbury Fox that too much attention is paid to the mere surface changes in the treatment of tinea tonsurans. The older dermatologists were greatly impressed with the necessity of giving internal medicine at the same time, and this is not surprising when we recollect that the fungus was not discovered until 1843. Knowing, as we now do, the life-history of the microsporon and the tricophyton our aim in treatment is to get rid of the fungus as quickly as possible. This can only be accomplished in two ways—(1) by the use of such anti-parasitic remedies which will penetrate easily into the hair-follicles and so destroy the fungus *in situ*, (2) by causing a rapid falling of the diseased hairs, so that when these are shed the fungus comes away with them. Up till quite recently, the first method was the only one commonly employed. The great difficulty has been to find a substance with sufficient penetrative powers that shall not prove too destructive, and I regret to say that we do not yet know of such an agent. If the cases of tinea tonsurans are seen early enough almost any germicide will be effectual. The popular use of ink is at least sanctioned by ancient authority, but it should be remembered that the "atramentum scriptorum" was a carbonaceous product and not a gallate of iron, as in modern times. From ink to gunpowder, the number of parasiticides which have been used is legion. Whichever one happens to be our favourite, whether it be carbolic acid, sulphur, chrysarobin, or mercury, let it be used thoroughly. Over-activity, however, is as disastrous as insufficient treatment is useless. It is very easy to produce an artificial kerion by the vigorous application of some strong preparation, and this may lead on to a condition of permanent alopecia—a most undesirable event. Such formidable remedies as formalin, pure carbolic acid, or croton oil need especial care in their application and should never be entrusted to parents themselves. There are certain general rules for the management of a ringworm case which it is essential to observe in order to obtain the best results:—(*a*) The whole scalp should be shaved when possible, particularly in boys, while a thin fringe may be left in front for the sake of appearance in the case of little girls; (*b*) the head should be kept covered with the ointment selected and a thin cap of old linen should be worn both by day and night. Soft paper is not a bad substitute for linen, if expense is a consideration; (*c*) too frequent washing of the scalp must be avoided; (*d*) epilation should be practised in and around the diseased areas as often as possible. I am in the habit of giving printed instructions for the management of ringworm to the parents who bring their children to the skin department at this hospital, based upon the above rules. I will now only mention a few of the many methods employed for the destruction of the fungus *in situ*. The application of an ointment containing β-napthol, sulphur, and vaseline; of tar and sulphur (the old "Wilkinson's ointment"); of Coster's paste, a mixture of iodine and tar; painting the area with salicylic acid collodion (Crocker); blistering with tincture of cantharides (Hallopeau). Equal parts of pure carbolic and salicylic acids (½ dr.-1 dr. of each to the ounce of vaseline or lanoline) make a useful ointment. If the case is able to be seen frequently, chrysarobin can be added cautiously to this latter ointment for application to the diseased patches only. The plan adopted by Abraham, of exhausting the air from the follicles by means of a special hand-pump and then running in creosote and iodine, is a most excellent one, and I have seen many cases of ringworm cured by this means.

The depilation method, as practised by Aldersmith, has also been successful, though it is not so easy to apply and carry out. By sopping the area with a saturated solution of boric acid in spirit and ether an artificial alopecia is induced, after which the new hair grows regularly and is found to be free from disease. In 1883 Aldersmith prophesied that an easier way of producing an artificial alopecia areata in the affected areas would be found, and now to-day we have the X-rays coming to our aid in the treatment of this most troublesome disease. Suggested by Freund, of Vienna, in 1896, it is only by the researches of that distinguished French dermatologist Sabouraud that the method has been rendered anything like practicable. The hair begins to fall out about a fortnight or so after exposure of the scalp to the rays, and the defluvium is complete in a week. In six weeks' time healthy hairs start growing again and in three months the disease is cured. This method has been employed in the treatment of ringworm in the Municipal Schools of Paris, and the saving of time and expense and loss of education has been very great indeed. It should not be forgotten, however, that the treatment is not altogether without its risks and attendant dangers, but there can be no doubt that in skilled hands it has proved and is

(*c*) MED. PRESS AND CIRC., 1903, i., p. 89.

proving a most valuable addition to our therapeutic armament.

When is ringworm cured? It is almost impossible to lay down a definite time-limit, as there are so many factors at work. In ordinary cases, if the hearty co-operation of the parents can be obtained, about four or five months is a fair average, though it must be admitted that many cases do go on for even years, in spite of all treatment. The point is "How does the hair grow?" If the growth is absolutely uniform, and the direction of the hairs is natural and even, then that patch is cured. It is generally wise to make a microscopic examination of any hair that looks at all suspicious before deciding whether a child is fit or not to go back to school. If no spores are discovered, the disease can be pronounced cured, but it is a good thing to advise that a little of the ointment be still rubbed in at night-time for another fortnight.

The application of a cap-film, such as that suggested by David Walsh, is a valuable means of preventing the infection of ringworm of the scalp spreading to other children. After shaving, the whole scalp is covered with a film of salicylic acid collodion, after exposing the diseased part to the X-rays, and the child can then attend school with perfect safety. This "scalp-isolation" is also indirectly curative, as it hastens the depilation of the hairs.

Ringworm of the body can soon be cured by painting with tincture of iodine or by the application of a mild ammoniated mercury ointment. In cases of tinea barbæ, depilation should be practised as far as possible, and the hairs clipped quite short. An antiseptic fluid such as cyllin, suitably diluted with warm water, is useful for bathing the affected parts, after which an ointment containing carbolic acid, sulphur or ammoniated mercury can be applied.

For ringworm of the nails, the plan of treatment devised by Harrison, of Bristol, is one of the best. It consists in scraping the nail well and immediately applying a solution of potash and iodide of potassium under oiled silk for a quarter of an hour. This is then taken off and a solution of perchloride of mercury, 4 grains, in equal parts of rectified spirit and water, up to ½ oz. is next applied and kept on for twenty-four hours. This is repeated as often as necessary.

Vaccine Laboratory.—The Government's new vaccine laboratory which is being built on the Collindale estate, Hendon, is expected to be opened shortly. The site covers more than two acres, and a sum of about £20,000 is being expended. The buildings, which will include operating room, heating station, and the necessary stable accommodation, are within a short distance of the British Museum's storehouse for newspapers.

ORIGINAL PAPERS.

TWO CASES OF RESECTION OF INTESTINE FOR MALIGNANT DISEASE.

By G. P. NEWBOLT, M.B., F.R.C.S.,
Surgeon Royal Southern Hospital, Liverpool.

Case I.—*Excision of the Cæcum for Colloid Carcinoma.*

Edwin G., æt. 38, a pawnbroker, was brought to me in April, 1904, complaining of a lump in the right ilio-lumbar region, which was giving rise to a good deal of pain.

His previous history was that he had had pain in the right side of the abdomen for twelve months, and had lost 16 lbs. in weight during this time. For the last three months the pain had been much worse, and a lump had been noticed in the right side. Four months ago he had an attack of diarrhœa and was jaundiced. At that time his liver was enlarged. Had always partaken of stimulants freely.

On examination, a tumour about the size of an orange could be felt in the right ilio-lumbar region. It was hard and tender, and could be pushed into the loin. At first it was thought that it might be a kidney growth, but the normal condition of the urine and the fact that the tumour was situated too far forwards and downwards rather negatived that idea. There was a band of resonance between the tumour and the liver which excluded disease of the gall-bladder, though the liver itself was slightly enlarged. There was at this time no constipation nor sickness. Patient was admitted to the Royal Southern Hospital on April 21st, 1904.

Here a careful examination and measurement of the urine passed excluded kidney disease, and the resemblance of the case to one of cancer of the cæcum which I had recently had under my care induced me to think that I was dealing with a growth of this part of the intestine.

On April 26th, the patient being under ether, I made an oblique incision extending from the right loin over the tumour nearly to the middle line below the umbilicus. On opening the abdomen a big growth involving the cæcum was found, and it was thought possible to remove it.

After having packed the intestines off with gauze, the ilium was exposed, clamped in two places and divided between, a little mucus being caught on gauze dabs, and the severed ends of the intestine and the clamps wrapped around with gauze.

The ascending colon was next isolated and treated in the same way, some adherent omentum being ligatured and cut away. The peritoneum external to the tumour was next dissected up from the loin and iliac fossa and the growth separated, except on its inner side. A V-shaped piece of mesocolon containing some enlarged glands was exsected and the mass removed. Many large vessels were tied, gauze used to pack off the wound, and the two ends of the divided gut brought together and united with silk. As the small intestine did not fit the large, a piece of the latter was puckered up and sewn over; finally the line of union was secured by Lembert's sutures all around, and some omentum used to cover in the joined parts. The edges of the V-shaped cut in the mesocolon and mesentery were carefully sutured. The wound being quite dry, all gauze was removed and the wound was closed completely.

Patient's condition after the operation was excellent. On the second day his temperature rose to 102° and he had a bronchitic attack, which speedily subsided. The wound healed rapidly, but had to be opened at one spot on the 14th day to let out some pus, and from this opening several bits of silk came away, but there never was any fæcal discharge. His bowels acted slightly on the 2nd day after operation, and again on the 5th day, when

a formed motion was passed. Six days after operation he was taking fluid nourishment freely. A month after operation had had a severe bilious attack, which however soon subsided.

His present condition is good; he feels well and has put on flesh lately, though his weight now is less than it was when he went into hospital, 9 st. 2 against 10 st. 8½.

I fancy his liver is slightly enlarged (Nov. 1904). The growth is a colloid carcinoma, involving the cæcum, but not causing any constriction of the lumen of the gut. From the size and nature of the growth, together with the fact that glands were enlarged, of course the prognosis is doubtful (fig. 1).

April 1905.—Patient continues in good health and has put on weight.

[*Note.*—June 1905.—Has secondary deposit in liver, and is rapidly wasting.

CASE II.—*A Case of Left Inguinal Colotomy for Intestinal Obstruction, followed by simultaneous Excision of the Growth, and artificial anus.*

On May 20th, 1904, I saw Mrs. H., æt. 53, suffering from intestinal obstruction.

Her history was as follows:—She had always enjoyed perfect health until the end of March, 1904. On April 2nd she called her doctor in for what she thought was a bilious attack. Purgatives acted freely, and nothing could be made out by external examination. As she did not improve and her abdomen began to extend, I was asked to see her.

On examination, her abdomen was much distended, especially in the flanks, and nothing in the nature of a lump could be felt externally or per vaginam or rectum. There was a distinct history of her passing ribbon-like fæces, and her mother died of cancer of the stomach. She had had ten children, the youngest being eleven, but there was no history of any pelvic inflammatory trouble.

On May 24th I did a left inguinal colotomy. The obstruction had now become acute, and I drained the bowel at once with a Paul's tube. In passing a pair of forceps under the distended gut in order to keep it out of the abdomen whilst I stitched it, the gut was accidentally perforated in two places; these I clamped off and closed, after I had sutured the gut to the edges of the wound and had drained the bowel.

At the end of August she came to see me, being anxious to have her colotomy wound closed if possible, her medical man having felt the growth through the upper opening of the colotomy wound.

On examination, I found that the lower opening was the artificial anus, or, in other words, that the bowel was twisted, and down the upper or distal opening a growth could be felt which was freely movable and some 2 inches from the artificial

anus. I therefore determined to excise the growth and leave the artificial anus for a time, but this did not suit the patient, who could not be brought to appreciate the benefit of her artificial anus, and wished to be cured at one operation.

I may say the artificial anus was acting well, and the skin around was in good condition.

On September 1st, after several careful preparations of the skin around the artificial anus, the latter was plugged with gauze, ether administered, and an incision made on the inside of the opening, a flap of abdominal wall was reflected and tied down over the artificial anus with sutures. The growth was found, clamped above and below, and excised with a piece of mesocolon; the gut leading to the lower or real opening was next clamped and divided between, and all bleeding having been stopped, end-to-end suture was performed. This was difficult on account of the contracted state of the distal end of the gut. The union was strengthened by being covered with a piece of omentum; some mesocolon containing glands wa next excised, and the edges of the opening closed with sutures. The colotomy opening was next excised, the inner abdominal wound closed, and the one in the site of the artificial anus partly closed and packed with gauze. Patient left the table with a pulse of 100.

Next day patient was very ill and suffered great distress from the fact that flatus was collecting behind the line of union, she vomited, her abdomen became a little distended, and her pulse ran up to 160; however, at 5.30 p.m. on the second day, flatus passed and her bowels acted slightly; after this her bowels acted regularly without an aperient, and she improved so rapidly that on September 29th, a month after operation, she was able to return home, and a letter which I received a few days ago said that she was quite well, got about as usual, and could eat anything.

The growth is an ordinary adeno-carcinoma of the bowel, and allows a quill to pass through the lumen; the glands in the mesocolon are enlarged.

The points of interest are:—

(i) The reversal of the colotomy opening, due to a half twist of the bowel, or to a very marked sigmoid curve.

(ii) The great objection to the colotomy wound by a strong healthy woman, although it acted well and the skin around was not irritated.

(iii) Whether it would not have been safer to have first removed the growth, bringing the distal end of the gut into the colotomy wound, and cutting away the spur later on.

My own experience of cutting away spurs is that it is a very tedious process.

"QUO VADIS?"

A PLEA FOR MORE COMMON SENSE IN THE PROPHYLAXIS AND TREATMENT OF DISEASE.

By CHARLES BELL TAYLOR, M.D., F.R.C.S.Ed.

Hon. Surgeon to the Nottingham and Midland Eye Infirmary.

MR. PRESIDENT AND GENTLEMEN,—When Molière, the great French dramatist, satirised the members of our learned profession, he declared that the whole art and science of medicine might be summed up in three words, "Purgare, Saignare, Glysterium donare," and if anything further was required it was simply—"Re-purgare, re-saignare, glysterium re-donare."

Voltaire, Le Sage, Hugo, and other eminent Continental writers have similarly criticised us, and that we do not lack a like sense of humour on this side of the Channel is evidenced by the popularity of that well-known skit upon the late Dr. Lettsom—

"When folks are sick they send for me,
I physicks, bleeds and sweats 'em,
Sometimes they live, sometimes they die,
What's that to me, I Lettsom."

Of course we laugh, Englishmen are always good-natured enough to laugh at themselves, but, after all, what is there to laugh at? I protest that the treatment, though Molière meant to be sarcastic, is rational enough; indeed, if he had added to his epitome of the art and science which we all profess, "Sudare, et blisterium imponere," it would have been to my thinking well-nigh complete. What, for instance, could be more in accord with the principles of common sense when called to a case of acute or chronic or threatened disease than to clear out the primæ viæ, to wash out the stomach with tube or emetic, to rid the colon of accumulated hardened or pestiferous fæces, to cleanse the skin with suitable baths, and to start the treatment with what Lord Rosebery would term a clean slate. Again, when we have to deal with congestion, inflammation, cell exudation and immigration, leucoccytal disturbances and the like, when we have robor, tumor, calor, dolor, throbbing, shooting, burning, what can be more reasonable than to cut off the supplies. to stop the beginning before it begins, to drain the gorged vessels and ease the raging pain by the abstraction of blood? We all know that tissue reaction to irritants with hypercellularity will cause almost any disease, carcinoma, for instance. Simple scratching will cause epithelioma, and the irritation of gall-stones cancer of the liver, while mere compression of an artery that supplies a painful part will stop the process and cure the neuralgia.

Compression of both carotids will cause instant insensibility, hence the term from "Karos," sleep. I have seen a patient, worn out from loss of rest and agonised with the stabbing pain of acute pleurisy, instantly relieved turn over and go to sleep as the blood flowed from a wound at the bend of the elbow Syme, the Napoleon of surgery, used to say, "If there is pain, take a few ounces of blood from the arm." Von Grafe said precisely the same thing if there was pain after cataract extraction. Alison, the late eminent professor of the practice of physic in the University of Edinburgh, used to tell us that "Forty years' experience had taught him the great value of blood-letting in the treatment of disease." I have seen horses with their eyes protruding, their nostrils dilated, their limbs fixed, and gasping for breath, relax, heave a deep sigh of relief and commence to feed as the blood gushed from a free incision in the jugular vein. I have known a woman afflicted with delusions murder two of her children, and then cut her own throat. As the blood flowed from the superficial self-inflicted wound the cloud was lifted, the written troubles of the brain were razed out, the eyes of her mind were opened, and with infinite horror she realised what she had done.

A friend of mine who incised the median vein with a razor has seen the same instant relief followed by complete recovery in a case of puerperal eclampsia. I have known and recorded cases of stalwart men, who were, humanly speaking, lost in their prime solely for want of bleeding. Whence this neglect, this dread of a simple operation which our predecessors practised almost every day of their lives? We have only to look at their diaries, day-books, and ledgers to find in the constant recurrence of "iter venesectio" ample confirmation of this statement. Are we so much wiser than our fathers? I doubt it! We have each about fifteen ounces of blood for every stone of weight, ten

(a) An address delivered before the Nottingham Medico-Chirurgical Society on November 15th, 1905.

ounces abstracted to-day is replaced by new and presumably better material within a fortnight, and there can be no doubt that it is wise to let out and replace with water or saline drinks blood that is effete or too thick to circulate freely, or that is poisoned by gas, opium, foul air, or auto-infection.

Venesection, too, is of infinite value in taking off the pressure from vital parts, which pressure, if unrelieved, as in cases of congestive apoplexy for instance, must end in disaster. If I find that the water does not flow freely in my bath-room, I know that they are running it off in the kitchen, and if I open a vein in the arm I interrupt, stop, arrest, or slow the hæmorrhage which is taking place elsewhere and which might prove fatal. Think of what this means when a patient is bleeding to death from the nostrils or lungs or intestines, who is threatened with cerebral hæmorrhage, who staggers in the street, or, breathing stertorously, falls convulsed upon the floor. Some years ago I operated on a patient for another affection who had long suffered from repeated attacks of epistaxis. After a somewhat prolonged exemption from his usual loss he was suddenly seized with violent pain in the head; he felt instinctively that he ought to be bled, and applied to three medical men in succession, begging each to open a vein. They all refused. "We never bleed now," they said. He went home disconsolate, was seized with a fit the same night, and died paralysed shortly afterwards. It is a mistake to suppose that the loss of a little blood, or a lot of blood for that matter, is of any great consequence. I once accidentally wounded an artery in my own person; the hæmorrhage could not be controlled, and I lost a tremendous lot of blood. On another occasion I put on twenty leeches; the bites bled more or less all day, all night, and most of the next day. I did not attempt to stop them, my clothes were saturated, and whenever I took a hot bath the water was literally incarnadined and resembled red ink. I did not on either occasion lay up for a day or interrupt my practice, and felt no worse. They used to bleed very freely in the Army; "pleno Rivo," or a hatful of leeches, or both, was a common prescription. One gallant soldier, an Irishman, bled by the order of Guthrie, said the treatment made him feel "powerful weak, but cruel easy." The men dealt with in this way for supposed malingering were positively drained and looked like ghosts, but I suppose they recovered, since we have no record of untoward events. The President of the Glasgow Medico-Chirurgical Society reports a recent case where two hundred ounces of blood were abstracted with the best results, and Benjamin Rush, a celebrated Quaker, physician of Philadelphia (who was libelled for his practice of bleeding by Cobbett, and recovered five thousand dollars damages), had in his time hundreds of similar cases. We all know what happens in cases of placenta prævia, in some cases of malignant disease, Bright's disease, accidental hæmorrhage and the extraordinary losses which women sometimes suffer in childbed, apparently without much detriment. A medical friend of mine practising in this county, and over eighty years of age, used to take off the pressure, as he termed it, *i.e.*, bleed himself, whenever he felt out of sorts. Both his arms, as I saw, were scarred with repeated venesections. He said the operation had saved his life more than once, and eagerly offered to open a vein in my presence. Why do we neglect so great salvation? The indication is so obvious, the treatment within reasonable limits so harmless, the results so immediate and gratifying that it is impossible to understand why such a valuable therapeutic remedy should have fallen into disrepute and almost complete disuse.

So much for "Saignare"; now as to Molière's "Glysterium donare": I do not think we can over estimate the importance of rectal alimentation in disease. Many patients have owed their lives to high enemata, and it is desirable that we should bear in mind that the colon is something more than a mere receptacle for refuse or effete material; it is really a most important assimilative and digestive organ. Professional starvationists owe their lives to the colon, entombed miners deprived of all sustenance except perhaps a little dirty water, will live for weeks, but not if they have diarrhœa; and by supplying nutriment by way of the colon, we utilise this function to the utmost, and give complete rest to the upper portion of the intestinal canal just as effectually as if we had opened the abdomen and performed gastro-enterostomy, or excised a portion of its contents. Straus mentions a case where a man was exclusively fed in this way for ten weeks, and the blood constituents did not suffer, nor was the power of the heart diminished. Moreover, it is easy to pass nutrient fluids through the ileo-cæcal valve, and when in the small intestine they are digested just as though they had passed through the stomach—indeed extra-buccal treatment, though neglected, is a valuable therapeutic agent, and it is clear that we cannot afford to ignore it, more especially since Professor Bourget, of Lausanne, and more recently Theodore Zannger and others have demonstrated that high enemata constitute the very best treatment for that "maladie à la mode," which we call appendicitis.

Bourget does not hesitate to bleed with leeches or purge his patients with castor oil, but he places his chief reliance on warm injections, rendered antiseptic by hermani ichthyol. These are passed through a long tube so as to reach the affected parts, and he declares that when this is done pain and tension cease as if by magic, that the temperature falls, and that agony is at once replaced by repose, sleep and speedy restoration to health. He also points out that even if pus be formed it may be absorbed or discharged innocuously into the bowel, or come to a head on the surface. Now it is notorious that unoperated cases of appendicitis as a rule do not die, it is also true that the mortality of patients operated on in the acute stage is excessive (at least 20 per cent.), and that the mortality of patients operated on in the quiescent stage is very low. The object of treatment must therefore evidently be to arrest the inflammatory process in the early stage, and to operate, if operation is necessary, when the acute symptoms have passed off, and this is precisely what Bourget does. He has treated upwards of fifty cases in this way; he gives minute details of the most interesting of them, and he assures us that he has had no operations in the acute stage, no accidents, and not a single death—"aucun cas de mort." Some of these cases were operated upon after recovery from the acute stage and exhibited the characteristic lesions of appendicitis, so that there can be no doubt as to the correctness of the diagnosis. He also points out that the removal of the appendix is no guarantee against subsequent attacks, and may even cause them; also that it is only when the parts have become gangrenous, or are approaching that condition, that the operation in the acute stage is necessary or justifiable.

"What say you, gentlemen— shall we operate on this case or not?" The six students and young surgeons who were in attendance at the bedside were of opinion that operation was not advisable. "You are wrong," replied the Professor, "I shall operate at once." "No you won't," exclaimed the patient, who was a betting man; "six to one is good enough odds for me, give me my clothes."

So much for glysterium donare; as to sudare and blisterium imponere we all know that the skin is the largest organ of the body, it is also one of the most important and most easily accessible; we can see its pores open and shut, it gives off several ounces of fluid every day, and it is easy to understand that any check to this natural function, especially in deteriorated constitutions, is apt to prove very serious. In short, common cold and its sequels are said to cause no less than one hundred and twenty thousand deaths in Great Britain every year. Much of this excessive mortality may be prevented and the colds aborted by

judicious management of the skin, hot baths, lamp baths, taken either in or out of bed, with Dover's powder, pilocarpine and quinine or salicylic acid; and quinine will often speedily terminate an attack which, if neglected in the early stages, might have proved fatal. Moreover, the function of the skin may be utilised so as to take off the heat and burden from internal organs. For instance, it will take on the functions of the kidney, and though in a less degree than the mucosa, vicariously eliminate urea; it will also supplement the functions of other internal organs such as the lungs, liver, pancreas, and spleen, whenever these important organs are oppressed or silted up by hard living, actual disease, injudicious diet, too much meat, gout, alcohol or tobacco. Here is a fine field for therapeutic endeavour, a field which has been cultivated by the most eminent hydropathic physicians, from Priestnitz, of Grafenberg, who never wrote a line, and yet attracted the crowned heads of Europe and distinguished patients from all parts of the world, to such well known ρ actitioners as Gully (the father of the late Speaker), Wilson and Edward Johnson, of Malvern, Currie, of Liverpool, and others. These gentlemen made the most of the skin, and by means of lamp baths, Turkish baths, compressed air baths, packs, hot and cold douches, water blisters and other counter-irritants, succeeded in securing excellent results in many cases that had baffled the most accomplished practitioners. We can also, by acting on the skin, independent of hydropathy, distract the attention of the nervous system and thus counteract morbid processes going on in deep-seated and vital organs. For instance, it is said there is no remedy so good for phthisis as the counter irritation of an attack of acute eczema in the shape of small-pox (Sir William Broadbent). The late Professor Syme used to treat cases of morbus coxarius with the actual cautery to the skin over the affected part, and, to use his own words, "the relief was no less speedy than complete." Mr. Pott used to cure paraplegia and ataxy by issues, setons and other counter-irritants placed in the cellular tissue alongside the spine—"one fire burns out another's burning." Shakespeare also tells us, "Take some new poison to thine eye and the rank venom of the old will die," and that is precisely what occurs. Let me illustrate my meaning: when the beetroot sugar industry in Germany was threatened with extinction through the ravages of a parasite called the eel-worm, Professor Kühn saved the situation by planting a worthless weed of which the worms were exceedingly fond alongside the roots; the parasites turned from their dainty dish to feed on garbage, and were cast into the fire; and we can do precisely the same thing in surgery. If a vital or important organ, such as the eye, for instance, is threatened with extinction or serious damage by inflammation, we can save it by bleeding with leeches and establishing another inflammation in a less vital organ, such as the skin near at hand. The attention of the nervous system is withdrawn from the threatened vital organ and expended elsewhere, while the materies morbi are diverted to some other part where they are harmless, and we are masters of the situation. We cannot over-estimate the importance of the nervous system in these cases. When a man suffers from rigor and shock such as sometimes occurs on the introduction of the catheter, and this shock is so serious as to be followed by suppression of urine, he will die from uræmia and acute congestion if you cannot speedily divert the attention of the nervous system from the kidneys to the skin. When a woman is seized with a rigor on the introduction of a foreign body into the uterus (as has happened in cases of criminal abortion), she will die unless you can speedily rouse and distract the attention of the nervous system. The same thing has happened and proved fatal in a case of hysterectomy, although on *post-mortem* examination all the organs were found to be quite healthy. The late Pope Pius IX. suffered from fits whenever an ulcer on his leg was allowed to heal. A child quite recently died in a London hospital from the too rapid healing of an eczema, though she was in other respects as healthy as healthy could be. When a delicate girl suffers from sudden and intense fright she is apt to develop palpitation and protruding eyeballs unless we can speedily distract the attention of the nervous system. When a paraplegic afflicted with hysteria is roused with a cry of fire she has been known to recover the use of her limbs and run downstairs, though she had been supine and helpless for months, or in some cases for years. Quite recently a cripple in London, passing a house on fire and, roused by the cry of a child, threw down his crutches, dashed into the house and rescued the baby. A lady, addicted to play but a bad loser, was one evening most unfortunate at cards; under the influence of the chagrin so occasioned she developed glaucoma and lost the sight of the right eye. Warned by this terrible mishap, she abandoned her favourite pastime for a year and a half, when, being tempted, she again ventured, was again unfortunate, and lost the sight of the remaining eye (Fischer). A distinguished engineer, during the siege of Paris, ascended in a balloon to make observations, was caught in a contrary current, driven into the enemy's lines, and taken prisoner. That same night he was attacked with glaucoma in both eyes (Wecker). A nurse, worn out with watching at the bedside of a dying patient, fell asleep and was suddenly roused by a loud crash—the sash cord had broken; glaucoma came on within an hour in the right eye, and the left was speedily affected in the same way (Lawson). Chorea, as well as glaucoma and Grave's disease before mentioned, epilepsy, paralysis, jaundice, paralysis agitans, blindness and acute mania have been caused by psychic disturbances, to which many persons are subject. We all know of the Indian method of detecting crime by the drying up of the salivary secretion, and the orator's trouble in the same direction, how the back "opens and shuts" on acute excitement, and how toothache vanishes when we knock at the dentist's door. Mock executions have on several occasions proved fatal, and in fact you can accomplish wonders by suggestion, hypnotism, mesmerism, Christian Science, and by acting on the mental and nervous systems of excitable or more or less mentally afflicted sufferers. In fact I have on several occasions restored the sight of patients suffering from hysterical blindness by drawing sparks from the eye.

To sum up, then, let us treat disease on common sense principles by removing the cause, by raising the standard of vital resistance, and by cultivating health.

"Crescit indulgens sibi dirus hydrops
Nec sitim pellit nisi causa morbi
Fugerit venis et aqueosus albo
Corpore languor"— Horace.

Let us realise the importance of attending to the primæ viæ by emetics, laxatives, and derivatives in the early stages of diseased conditions. Let us stop inflammatory processes *ab initio* by judicious depletion. Let us utilise the colon as an assimilative and digestive organ in all diseases requiring rest for the upper portion of the intestinal tract. Let us get at the *fons et origo mali* in cases of typhlitis, perityphilitis, and appendicitis by judicious local depletion, counter-irritation at McBurney's point, opiates and high enemata. Let us recognise the importance of the skin as an absorptive, depurative and vicarious organ. Let us soothe and guide and distract the roused and ofttimes destructive reaction of the nervous system. Let us fully recognise the vast importance of the principle of counter-irritation, and above all, let us do no harm!

When a certain Scotch young lady was told that the late Queen had taken chloroform, she said "she didna ken it had reached so fair sooth as London," and in my humble opinion it is a pity it ever did reach London; it is, in fact, a lethal agent, has caused

thousands of deaths, and no doubt will cause many more, whereas ether is as safe as safe as can be, especially when given by the Joyce-Jeffries or open method; it is excellent for children, quite as rapid as chloroform, and when nebulised, as I have proved, by nitrous oxide, quite as pleasant to take. "Which anæsthetic will you have, gas or chloroform?" "Oh, ether will do." We all know what good medicines will do in certain cases, but I fear we do not always realise what harm may sometimes ensue from their administration. "Did Mrs. Smith take her medicine?" "Yes." "How do you know?" "I saw the blinds were down!" Digitalis is an ideal drug, especially when given in the form of freshly prepared infusion, notably in cases of dropsy. Nevertheless, I have known patients and friends of my own die very suddenly on change of position when taking small doses of the tincture, a much more dangerous preparation. I have known a distinguished physician prescribe a favourite mixture of his in bronchial affections for upwards of thirty years; at last he took it himself—and never ordered it again. Never give bromides to patients over sixty-five years of age, and let us not forget that arsenic in medicinal doses has been reasonably credited with causing cancer. Mercury is one of the most valuable of remedies; it should be given, however, in the form of blue pill in full doses or by inunction. In cases of hard chancre it completely aborts constitutional syphilis (Hutchinson), and so long as the weight of the patient is not diminished it may be continued indefinitely. A mixture containing a small proportion (one-eighth of a grain to the ounce) of biniodide of mercury is a specific for diphtheria (Luff), while intubation is a vast improvement on tracheotomy, which last operation is exceedingly difficult to perform on infants and very small children. Eliminating meat and salt from the dietary is excellent treatment in gout, rheumatism, migraine and allied uric acid affections. It is worth while remembering that people who are taking salicylates do not catch cold, and that a strong solution of salicylate of soda is one of the best gargles for catarrhal sore throat. Tobacco smoking is a fertile cause of amaurosis and other nervous affections, as also of cancer of the lip, tongue and throat. "How is it that you use so much tobacco?" said a wife to her husband. "Because I chews," was the reply. Yes, they chew when they cannot smoke, and some, it appears to me, would rather smoke than see. On the other hand, opium smoking is a valuable therapeutic remedy far too much neglected. Setons at the back of the neck and subconjunctival injections of saline solution dionine (2 centigrammes) is excellent treatment for infiltration and detachment of the retina, as is also the insufflation of powdered dionine into the conjunctival sac. It is a mistake to ascribe everything to syphilis; "omne ignotum pro syphilitico" is, I fear, a justifiable reproach. "There is a typical case of syphilitic teeth," said a physician to his class. "Perhaps you would like to examine them more closely," said the patient, removing the set from his mouth. It is recorded that Sir Benjamin Brodie once ordered some medicine for a patient, and then sent his man full gallop after the messenger, to say that they were to try it on a dog first. I have known a patient take a dose of mixture and instantly fall convulsed and senseless on the floor. The doctor who had ordered the medicine was sent for, and arriving in hot haste, took a dose himself just to show there was no harm in it, and at once fell convulsed and senseless beside his patient (the dispenser had substituted cyanide for bromide of potassium). Precisely the same thing happened in the case of the Duke of Athol, who had five physicians—two declared he was poisoned; one of the two insisted on tasting the contents of the stomach, and was immediately seized with symptoms of acute poisoning himself. Indeed, we cannot be too careful.

Let us realise that in giving expert evidence both sides must be heard if justice is to be done, and this is especially important in the very first stage of the inquiry. If there is a chemical analysis, or a *post mortem* examination, or an examination of the plaintiff's person in cases of alleged outrage or injury, the accused must be represented while there is time to refute or criticise the evidence for the prosecution, and before the accused is committed for trial. If this precaution had been taken in the Mattersea rape case, in the Chesterfield rape case, in the Grimsby starvation case, the innocent persons who were found guilty and subsequently liberated (on my own petition) would not have been convicted. Certainly we may say the same with regard to the expert report on the handwriting in the Adolph Beck case, and perhaps also with regard to the chemical analysis in the Maybrick case, and the examination of blood and horse hair in the Edalji case.

With regard to the prophylaxis of disease considered apart from the treatment of disease. We all know that in ordinary circumstances "prevention is better than cure," but prevention is *not* better than cure when the remedy is worse than the disease. The late Contagious Diseases Acts (Women) was a glaring instance of this, indeed we err if we suppose that we can afford to tamper with plain right and wrong, our own consciences tell us in a moment what is right and what is wrong. "Æquitas ipsa lucet per se, dubitatio cogitationem significat injuriæ," and if we do wrong or induce others to do wrong, or sanction wrong-doing, we may rest assured that we are on the wrong track, that Nemesis awaits us, and that, in short, it is impossible to do wrong and come out right. We may thank God that it is so, for a crime that succeeds is worse than a crime that fails—there is no end to its evil influence. Without doubt, it is wrong to torture animals under pretence of advancing science by vivisection. Nothing can be right that is unjust or cruel, and deliberate cold-blooded and prolonged torture of innocent and unoffending animals is both hideously unjust and atrociously cruel. Indeed, it is not to be borne, the humane sense of the community will not suffer it—revolts against it, and will certainly abolish it. Without doubt it is wrong to compel men, women and children, either by direct or indirect compulsion, to submit to inoculation with small-pox, cow-pox, typhoid fever, plague or any other disease. As Professor Francis Newman has remarked: "Against the body of a healthy man or a healthy infant, Parliament has no right of assault under pretence of the public health; the law is an unendurable usurpation, a tyrannical wickedness, and creates the right of resistance." Without doubt it is wrong to compel medical men to violate the oath which they take on inauguration and to betray the most sacred secrets of their patients to the executive. Without doubt it is wrong by force to aggregate and imprison rich and poor alike—those who have ample accommodation at home, and those who have none—in so-called isolation hospitals.

Without doubt it is wrong to subject men, women, and children who have merely been bitten or licked by dogs or other animals to the awful risks of the hypodermic injection of rabid matter; upwards of 2,200 have already perished after undergoing the process, and although there is no compulsion in this case, public money is spent upon it, and it ought to be banned both in the interests of society and humanity. Without doubt it is wrong to inoculate healthy horses with glanders on pretence of seeing whether they have got glanders or not, or healthy kine with tubercle on pretence of seeing whether they have got tubercle or not, or with anthrax or tetanus on pretence of preventing anthrax or tetanus. Without doubt it is wrong to inoculate healthy horses (who are very prone to lock-jaw) with glanders, with tubercle, and repeatedly with the most malignant diphtheria merely to utilise the product so obtained in the treatment of sore throat. It is a mistake to suppose that the introduction of so-called antitoxin has resulted in a diminution in the mortality from diphtheria, and it is a mistake to suppose that Germany has secured

immunity from small-pox by repeated vaccinations, It was by the substitution of intubation for tracheotomy, and the use of the biniodide of mercury, as recommended by Dr. Luff, and the similar employment of the salicylate of iron as suggested by Dr Gray that diphtheria has been robbed of its terrors' and it was by the expenditure of hundreds of millions (the French indemnity) in hygiene and public works that Germany has secured comparative immunity from small-pox. "To insist on doing in one way that which can only be accomplished in another" was Pascal's definition of tyranny, and after all, when so-called science has said its last word, it is to hygiene and the strengthening of the vital resistance of the individual that we must look for such advance as is possible in the prophylaxis and treatment of disease.

THE OUT-PATIENTS' ROOM.

ROYAL FREE HOSPITAL.

By T. P. Legg, M.S., F.R.C.S.

Tumour in the Thigh of Uncertain Nature.—A man, æt. about 47, was sent up to the hospital suffering from a swelling in the lower and outer part of the right thigh. The history was that twelve months ago he was struck in this part of the thigh by a motor car. Immediately after the injury, except for the bruising, he noticed nothing abnormal. Five months later the swelling was discovered, and had gone on steadily increasing to its present size, which was about that of a large orange. There had been no pain and no interference with the functions of the limb. On examination a firm elastic lobulated tumour was found situated in the muscles on the outer and anterior aspect of the right thigh in its lower third. The upper part of the growth had a well-defined edge, the lower edge was not very distinct. The skin was quite normal over the whole tumour and was quite free of the growth which, last could also be easily moved in a lateral direction over the shaft of the femur. On making the patient put the muscles into action the tumour became more prominent and harder. There was no sign of fluctuation, and the whole of the thigh was larger than the opposite one. On the upper and inner side of the same leg, about three inches below the knee-joint, there were two horse-shoe shaped ulcers separated at each extremity by a narrow bridge of skin; their edges were steep, sharp cut, and their bases smooth. There were no other lesions in other parts of the body, and the man looked healthy. What was the nature of the swelling? Mr. Legg said in diagnosing any tumour or swelling the first thing to make up one's mind upon was—where is the tumour? and not, what is it? This tumour was in the muscles. Now the only common tumour in a muscle was an inflammatory one, and in this particular case there was good evidence in the ulcers below the knee that the patient was suffering from syphilis, and the first impression would be that the mass was a gumma. Against this view was the fact that the tumour had been present so many months and had not yet involved the skin nor broken down into an ulcer; the alternative diagnosis to make was one of new growth, either a sarcoma or an innocent tumour such as an intramuscular lipoma. These latter were quite uncommon, and except for the lobulation there was really nothing to suggest a lipoma; besides, if the history was to be relied upon, it was unlikely that a tumour of this kind would have reached such a size in seven months. As regards the tumour being a sarcoma, the surgeon, Mr. Legg, pointed out, could only make such a diagnosis by a process of exclusion. Other possibilities, however, occurred, namely, that the swelling was a hæmatoma or ruptured muscle following the injury; but both the local signs and the history that nothing was noticed for five months after the accident were against such a diagnosis, and there was nothing to suggest a tuberculous nature of the swelling. Mr. Legg thought that inasmuch as the patient had not had mercury but only iodide of potassium, it would be advisable to put him on full doses of the iodide and also gr. ij. of hydrarg. c Creta twice a day for a fortnight to see if any effect were produced on the tumour. If there was no perceptible diminution in size, he considered that the best thing would be to cut the swelling out and ascertain by microscopical examination, if necessary, the nature of the growth. In reference to what he had previously said regarding the differential diagnosis of inflammatory swellings from new growth, attention, he said, should be carefully directed to two points—first, the edges of the swelling, which in the former are generally not well defined, and shelve off gradually into the surrounding tissues; in the latter the edges are often defined, sometimes even steep, although these characters may not be equally marked in all parts of the swelling. The other point to which attention should be carefully directed was the lumpiness or lobulation of the swelling; for example, a lipoma was frequently definitely lobulated, a sarcoma was very often lumpy or nodular, and at an early period becomes fixed to adjacent parts. In the present cases, these points were well illustrated; lobulation was evident, there was a well-defined edge in one part, and not so well defined in the lower part, thus making the diagnosis obscure, and in such cases all the factors have to be considered. As he had already pointed out, the man was suffering from gummata, and it was always a rather risky thing to diagnose two diseases in thesame patient at the same time, unless the evidence of each disease were indisputable, so that the first thing in this patient was to exclude by a therapeutical test if possible that the swelling was a gumma. Sometimes gummata do not yield readily to anti-syphilitic treatment, and therefore as there was a doubt in the diagnosis, further means to determine the nature of the swelling must not be unduly delayed.

OPERATING THEATRES.

ST. BARTHOLOMEW'S HOSPITAL.

Removal of the Whole Upper Extremity.—Mr. McAdam Eccles operated on a man, æt. 40, who nine months before had noticed a small hard swelling at the back of the upper part of the right arm immediately below the axilla. When seen there was a large fluctuating swelling simulating a synovial cyst. On exploration a growth was discovered, but the patient would not submit to its removal at the time. Shortly afterwards, however, he consented to the removal of the upper extremity which was considered the best means of eradicating the disease. The skin incisions had to be so planned that the longer flap was obtained from the front and outer side of the shoulder; a semilunar incision was therefore made from a point just internal to the middle of the clavicle outwards over the shoulder and down the arm to the insertion of the Deltoid. The clavicle was then sawn through at the junction of the inner with its outer two-thirds and the third part of the subclavian artery exposed, ligatured in two places and divided between; the subclavian vein was treated in a similar way. The brachial plexus was next severed, the connective tissue in the axilla torn through and both Pectoral muscles divided close to their insertions. A second incision was now made from the middle of the clavicle downwards and backwards over the scapula to meet the lower end of the anterior incision. The transversalis colli artery having been ligatured, the Trapezius, the Levator Anguli Scapulæ and the Rhomboids were cut across, the Omo-hyoid being the last muscle to be severed. The whole upper extremity was now detached and quickly removed. The patient did not show any signs of shock. All small vessels that exhibited any tendency to bleeding were secured and the skin flaps brought together and retained in position

by silkworm gut, interrupted sutures, and a drainage tube was inserted at the lower and posterior angle of the wound, the rest being sealed by gauze and collodion dressing. Mr. Eccles said that removal of the whole of the upper extremity was fortunately a somewhat rare operation, seeing that the mutilation was very great. Sarcoma was the chief indication for the proceeding. The new growth in this case had commenced at the origin of the long head of the Triceps and had been associated with a large blood cyst, which obscured the growth itself and gave rise to an erroneous impression that the case was one of a simple synovial cyst. Having decided upon the necessity of the removal of the whole of the upper extremity Mr. Eccles said he was confronted with the difficulty of planning his incisions in such a way as to secure enough skin and yet to keep very wide of the region of the growth. Division of the clavicle early in the operation and prompt ligature of the subclavian vessels were, he considered, important steps, as they enabled the operation to be carried out with a minimum loss of blood and consequently with the slightest amount of shock. The cords of the brachial plexus, he said, should be divided close to their exit, from between the Scaleni muscles so that the future bulbous ends might not be pressed upon by any artificial apparatus that might be applied. Drainage for the first twenty-four hours was, he thought, generally advisable and, if asepsis had been obtained and maintained, healing would be rapid and convalescence short.

The tube was removed on the following day, only a small quantity of blood-stained fluid being drained away. The patient made an uninterrupted recovery, the temperature never rising above normal and the wound being healed throughout in ten days; the man left the hospital twelve days after operation.

AMPUTATION AT THE HIP JOINT.—On the same afternoon the same surgeon amputated at the hip joint the right lower extremity of a young man, æt. 19, for Infantile Paralysis. The limb had been useless since the patient was two years of age and had been constantly the site of trophic ulceration and of inconvenience when walking. Mr. Eccles made a circular incision at the junction of the upper and the lower two-thirds of the thigh cutting through all structures down to the femur, pressure meanwhile being exercised by an assistant's finger on the femoral artery at the level of Poupart's ligament. The main vessels of the limb were then secured. In doing this Mr. Eccles said it was interesting to note that owing to the trophic changes brought about by the paralysis, these vessels were very small (the artery being not more than the size of the upper part of the radial). An incision was then made down the outer side of the limb from half way between the crest of the ilium and the top of the great trochanter to meet the circular incision. The muscles (atrophied) were rapidly raised from the bone in front and behind, and the head of the femur disarticulated. All further bleeding vessels were tied and the flaps united both along their vertical and their transverse edges with silkworm gut interrupted sutures; the wound was dressed without drainage with a collodion and gauze covering. Mr. Eccles said it was interesting to have an amputation at the hip joint on the same afternoon on which he had performed removal of the whole of the upper extremity, these two operations being the most severe amputations in surgery. This second case, however, was one of an atrophied limb and consequently the shock was far less than it would have been in the case of a patient with a normal lower extremity. The first essential, he considered, in an amputation at the hip joint was to secure asepsis, which was not altogether easy because of the nearness of the wound made by the surgeon to the genitals and anus. He thought that the method he had employed—namely a circular division at the junction of the upper with the lower two-thirds of the thigh together with a vertical incision on the outside was the best plan. He pointed out that the circular incision was made very much higher up than in the usual description of Furneaux Jordan's operation, and he stated that he considered that most text books on operative surgery placed the incision much too far down the limb—namely, in the lower third of the thigh. In amputating at the hip joint when the limb was not atrophied. Mr. Eccles said he would use drainage for the first twenty-four hours. Disarticulation at the hip joint for injury, he pointed out, had a very heavy mortality, but removal of the limb at this joint for disease was not nearly so dangerous to life as was usually thought.

The stitches were removed a week later, the wound was soundly healed in a fortnight, and the patient, being taught to walk with crutches, left the hospital eighteen days after the operation.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Sept. 2nd, 1906.

DIAGNOSIS OF MENINGITIS.

DR. MONTAGNON, physician of the hospital at St. Etienne, read a paper before the Congress for the Advancement of Science, held last month at Lyons, on "The Research and Signification of Albuminous Reaction in the Cephalo-Rachidian Liquid Observed in Meningitis in Children."

Since Quinck advocated puncture of the rachis in the lumbar region in 1893, an excellent means of diagnosing meningitis has been added to those already at our disposition.

However, the study of the modifications of the cephalo-rachidian liquid in the different meningeal reactions had not yet attained sufficient regularity to be regarded as a sure means of diagnosing the nature of the reaction.

Yet in the majority of cases, the modifications observed (lymphocytosis, change in colour density, chemical composition) constituted very important signs of inflammation of the membranes when the clinical symptoms were, as it frequently happens, somewhat obscure and excusing a certain hesitation on the part of the treating physician both as to the nature of the affection and the gravity of the prognosis.

That research was particularly useful in children so subject to inflammations of the coverings of the brain, and for which the attendant was always anxious to pronounce with probability as to the mildness or gravity of the affection.

Although it cannot be said that a sure and infallible sign has yet been discovered, yet the lumbar puncture, in the majority of cases, persisted in uniting the signs furnished by the examination of the different modifications of the cephalo-rachidian liquid, to arrive at a very precise diagnosis.

Many an attendant, says Dr. Montagnon, has been embarrassed at the bedside of the patient to know if he had before him a case of true meningitis or one of those cases of pseudo-meningitis giving clinically all the symptoms of tuberculous meningitis, yet how different in their termination.

Heretofore, before the lumbar puncture was practised, many cases of tuberculous meningitis were cited as cured which were in reality but the pseudo cases already mentioned (reflex, vermicular, or of hysterical origin).

Up to the present, the presence in excess of lymphocytes in the cephalo-rachidian liquid had been regarded as characteristic of the gravity of the disease.

Still more recent researches tended to prove that the presence of numerous polynucleares in the liquid coincided with the aggravation of the malady.

Finally, an excess of albumin in the same liquid, as observed by Dr. Montagnon, would seem to constitute the best sign in making a correct diagnosis and prognosis of meningitis.

In the normal condition, a small quantity of albumin is found in the cephalo-rachidian liquid (0·20 per cent.) corresponding, when treated with a few drops of nitric acid, to a very slight cloud. But when the membranes are inflamed, the quantity of the albumin increases notably.

Of four cases treated recently by Dr. Montagnon, three terminated fatally and the fourth made a good recovery. In the former, the increase of albumin in the cephalo-rachidian liquid was intense and progressive, while in the latter, which clinically presented the same symptoms, the cytologic and albuminous reaction were normal.

It is evident that the only certain proof of tuberculous meningitis is the presence of the bacilli of Koch, but with the signs already referred to and particularly that of albumin in excess, presumption may yield to certainty.

An excess of albumin may consequently be considered as the synonym of intense inflammation of the membranes of the brain and as meningitis in children is almost always (98 per cent.) tuberculous, the increase of albumin in the liquid is the equivalent of tuberculous meningitis.

Thus each time, concluded Dr. Montagnon, that children present some signs of inflammation of the brain, the lumbar puncture should be made and the liquid examined for albumin; if it is found in excess the prognosis must be grave, if on the contrary and in spite of alarming clinical symptoms no more than the normal quantity of albumin is found to be present, a favourable opinion as to the issue of the malady may be entertained.

Treatment of Scabies.

Carbonate of soda, 1 oz.
Sulphur flowers, 3 ozs.
Glycerine, 6 ozs.
Gum adragante, 15 grs.

The patient rubs himself with ordinary soap for half an hour, then takes a bath, followed by smart friction with the above mixture. The following day and for two or three days afterwards, the patient will take a starch bath (one pound of starch for each bath), and powder himself with the same substance.

GERMANY.

[from our own correspondent.]

Berlin, Sept. 2nd, 1906.

A New Method of Gastrostomy.

Prof. Favel, of Berne, has recently published notes of a new method of performing the operation of gastrostomy to which a reference is made in the *D. Med. Zeitung*, No. 66, 1906, as follows: All the older methods of performing the operation have the disadvantage that the opening made closes easily or becomes small, and that the wall of the stomach is fixed to the abdominal wall. This can be avoided when the stomach is attached to the skin by the intermediary of a loop of intestine, that is, allowed to retain its mesenteric attachment. This is formed like a new œsophagus, with its peristaltic action functionising towards the stomach. The only disadvantage of the operation is that it takes up a longer time than the other method.

Meat Poisoning and Gastric Crises.

From the same journal we note a serious and suggestive case taken from the *Charitee Annalen*, 30 Bd., S. 98. A man, æt. 31, after partaking of meat that was suspected of not being good, was attacked by severe abdominal symptoms, which were held to be the result of his partaking of unsound food. Later on, however, it was discovered that the attacks were really due to commencing locomotor ataxy, and were the usual gastric crises of that disorder. The patient died, and the autopsy confirmed the later diagnosis. On the ground of a medical opinion that favoured the poisoning theory the patient had entered an action against the butcher who sold the meat, claiming for bodily injury resulting from the use of it. The butcher gained the verdict as regarded poisoning by unwholesome meat, but he was convicted of unlawful proceedings otherwise as regarded the meat (the addition of boric acid).

Bier's Stasis in Diabetes.

Dr. Karl Grube has a paper on this subject in the *Munch. Med. Woch.*, 29, '06. Bier's hyperæmia is such an important matter that it has been declared to be the greatest advance made in clinical surgery since Lister's introduction of asepsis. The author has employed the process in diabetics both in milder and severer cases, as well as in furuncles and carbuncles and has found that as compared with other lines of treatment it has many advantages, that it is less severe, that it leads more rapidly to healing, and that in severe cases it seems to protect against the onset of coma.

Latterly the writer has treated diabetic gangrene by hot air, and very successfully. The foot or extremity affected is exposed to hot air for an hour each day. The temperature of the air is from 60 to 65 C.; higher temperatures are not necessary, and they may even be injurious. The action is this: The pain that is often very severe disappears usually after even a few sittings; the feet, previously livid and cold, take on a normal appearance, and any ulcers present usually show a tendency to rapid healing. It is an especially good sign, too, when the feet which had hitherto remained dry, showed a tendency to sweat. When carried out properly, the writer has never seen any bad results following it, but, on the contrary, frequent improvements. He has carried out the treatment in about twenty cases. It is necessary to watch the cases carefully, whilst the treatment is being carried out.

The *Charitee Annalen* contains also the following cases of interest on account of their being unusual terminations to perityphlitis: A man, æt. 39, had first symptoms of perityphlitis a year after he had been relieved of his appendix vermiformis. An operation showed the presence of adhesions, after the separation of which recovery took place. In another case the valvula Bartini closed up from chronic perityphlitis. The patient died from collapse after the operation that was performed for the relief of the condition. The third case was remarkable in that the perityphlitis was complicated by the hæmorrhagic diathesis. Hæmorrhages took place from the stomach, intestines, nose, kidneys, and skin, and to this the patient finally succumbed. In the fourth, pyopneumothorax resulted from a perityphlitis without any perforation of the diaphragm. It probably arose in connection with a development of gas from colon bacilli. A large quantity of pus was set free at the operation. In a fifth case, the interest lay in the onset of a perityphlitis in a pregnant woman (premature labour), and in the peculiar route taken in the evacuation of the pus—through the labium majus. In the fourth case recovery took place after bursting of the collection into the bladder. In the last case after a 10 pfennig piece had been passed *per via naturales*.

An interesting point is that not infrequently groups of cases appear as during an influenza period, for instance. As regarded diagnosis the writer had only made use of the counting of the leucocytes along with the other clinical symptoms. The comparison of the temperatures in the axilla and that in the rectum was scarcely likely to aid diagnosis. Therapeutically, morphia was advisable, as it relieved pain without

materially influencing peristalsis. Operations were undertaken when the exudation was extensive, when the general symptoms were grave, and when symptoms of threatening perforation were present.

AUSTRIA.

Vienna, Sept. 2nd 1906.

RÖNTGEN DIAGNOSIS.

JAKSCH, at the Prigue "Verein," related his experience in the diagnosis of disease by means of the Röntgen rays. Three hundred cases had come under the radioscope and every one of them had distinctive feature for diagnosis. Pyopneumothoras and tubercle can be diagnosed by the peculiar shadow of the latter, scars of old tubercle that have healed are clearly distinguishable in the pulmonary tissue. In cases of pneumonia the daily progress of the infiltration of the lung can be accurately followed and confirmed by percussion. The solution of the solidification commences in the centre, as a clear space in the shadow which coincides with the fall of the temperature. Atelectasis has the same general outline as infiltration, but the former is slightly clearer. Pleuritis and tumours are easily diagnosed, but anything in the mediastinal space is hard to differentiate. Mammary carcinoma may be mistaken for a tumour in the lung. In the case of pneumonia from the presence of a foreign body the latter could not be observed, while the pneumonia could be easily diagnosed. He admitted that infiltration, atelectasis, and fibrinous pneumonia were difficult to differentiate and required further physical examination. In cardiac disease the size of the heart is the only information obtainable. Hypertrophy, aneurysms, and atheroma in the peripheral vessels were shown in photos produced. A special case of atheroma tibial postica or what Charcot gave as the cause of Claudication intermitt nt was well illustrated. Basedowii, hepatitis, acromegalia, etc., with syphilitic cicatrices in the interstitial tissue of the liver.

Eckstein drew attention to the case of the foreign body in the lung that could not be discovered. It turned out to be part of a nutshell that had passed down the bronchi. He thought this difficulty was due to the equality of specific gravity as the nutshell was about the same as the lung. With a foreign body of a different specific gravity, the difficulty would have been less.

The same hypothesis prevailed in all diseases of the liver. He would assure the meeting that fine tuberculous centres were not so easy of diagnosis as Jaksch would have us believe. His method of ventrodorsal examination is sometimes unavoidable, but for accurate diagnosis of the apex of the lung the dorso-ventral is the more exact, as it obviates the error or confusion caused by the osseous structure and thick muscles of the neck. Again, the lung should be taken in a state of repose, and not with one or two minutes of exposure. This obviously leads to an error where fluids are present as he pointed out in his demonstration.

VIRULENCE AND AGGRESSION IN TUBERCLE.

Oscar next related his experiments with tubercle in guinea-pigs. After the disease has been imparted to an animal there is a period of hyper-sensitiveness when a new quantity of the bacilli injection suddenly reacts on the animal and speedily kills it. The post-mortem reveals an exudation in the peritoneal cavity which contains lymphocytes but no phagocytes. If another animal not in this hypersensitive condition be injected with a larger amount of the bacilli it may not or it may slightly affect the animal which will live through a protracted illness and finally die. When examined in the same way a very large number of phagocytes will be found in the exudation.

Again, if a small quantitv of the infecting bacillary fluid be injected along with the serum of a hypersensitive animal, into another guinea-pig acute tuberculosis will be induced. In this case no phagocytes will be found, or, if found, will be in small numbers at the very end, while large quantities of leucocytes will be found at the centre of infection.

Virulence and aggression are, therefore, different quantities. "Aggressivität" inhibits the concentration of the leucocytes around the infected centre and prevents the phagocyte from protecting the hypersensitive host.

The hypersensitive animal is one without that power of resistance against any new invasion of the bacillary poison, or where no phagocytes are present to take up the defensive immediately and destroy the new force brought suddenly into the field. The action of this poison is to increase the circulation at the centre which admits of rapid action when tuberculin is injected to counteract.

At the beginning of a tubercular attack this power of "Aggressin," is small and allows the body time to prepare for resistance, but as time goes on this aggressive power becomes stronger and finally triumphs.

LETTERS TO THE EDITOR.

THE SUPPRESSION OF QUACKERY.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—My statement that no editor of a lay paper dares nowadays to attack quackery evidently needs qualification. A very important exception must be made. *Truth* is with us; the Editor knows the extent and magnitude of the evils we seek to combat and if he will take up the question with the vigour he has displayed in other similar enterprises the hope of ultimate success must be, to say the least, very largely increased. As there seems a danger of some little misunderstanding of my suggestions, I should like to repeat that I propose that our energies be first of all directed entirely to the demand for a Royal Commission. Unless this is kept in view all other efforts will be thrown away. There will be no difficulty in producing overwhelming evidence as to the urgent necessity for medical law reform, and for legislation to control the quack's medicine trade. The movement cannot be successfully carried on without the sympathy of the profession as a whole, and perhaps the co-operation of representative professional bodies. I should hope that it would in due course be taken up by the British Medical Association. The Association might help provide funds. A large sum will be needed. Five to ten thousand pounds would, I think, not be too much to ask for. Some of this, or a great part, might be drawn in the end from the public. If by the activity of *Truth* and other agencies, the facts regarding the cruelty of quackery and the misery it is inflicting upon simple sufferers were exposed there could be hardly a doubt that many wealthy philanthropists would be induced to help. But I repeat, the profession, if help from outside be refused, is quite able to do the work itself. The great bulk of medical men are poor, but there are enough who can afford to contribute to a fund, and a minority whose large incomes should enable them to find all that is needful themselves. If the movement progress an executive body must be constituted to direct the movement, and, on the granting of a Commission by Parliament, to gather and arrange evidence and present it properly before the Commission. It is here that money would be needed. Counsel would probably have to be engaged, witnesses skilled and unskilled, of certain classes, would have to be paid, whilst a large expenditure would be involved in the analysis of the various classes of medicines the authoritative exposure of the composition of which would suffice to demonstrate their harmful and fraudulent character.

I am, Sir, yours truly,

HENRY SEWILL.

August 30th, 1906.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—A medical leader writer on the staff of the *Times* contributes an article on August 21st on the subject of sanitary administration by local authorities. The article is really an indictment of the authorities,

all of whom neglect, more or less, and some neglect entirely, the duties they are morally bound to carry out. The people, too, are in many instances to blame. "They will take quack medicines by the gallon," but will not compel their local rulers to carry out the elementary necessities of sanitation prescribed in Public Health Acts. The writer emphasises the recent utterances of Dr. Ray Lankester at the British Association anent the urgent need to teach our people "to make use in public affairs of the kind of knowledge called science." What must be the feelings of this able writer when he turns to the advertising columns of the great paper on which he is employed and finds there the puffs of the quack medicines which "the people take by the gallon," showing thus their scorn of the science he is engaged in upholding. I do not speak of the issue of the *Times* of August 21st, but of those within the past few years. During all this time advertisements of quack medicines have constantly appeared the character of which must have shocked the writer of the leader in question as well as every man of the world engaged upon the great journal. Is it possible the managers had not learnt from these gentlemen the nature of the quack medicine trade, that they have not had their attention called to the articles (quoted lately in the Medical Press) in which the traffic was denounced by their own editors in the strongest terms. If people "swallow quack medicines by the gallon," it is very largely due to the fact that they are advertised in the *Times*.

I am, Sir, yours truly,

An Obscure Practitioner.

August 24th, 1906.

THE DECLINING BIRTH-RATE.

To the Editor of the Medical Press and Circular.

Sir,—It is probably due to my density rather than to Mr. Clement H. Ser's lack of lucidity, but I must confess I do not understand his statement and argument. We have at any rate in France a complete object lesson in the effects of artificial restriction of population both upon individuals and upon the State. We are following the example of the French, and there can be no doubt that if we, like them, push it to its logical conclusion similar efforts will be produced. The French are a dying race. Their wealth accumulates whilst their men decay. Fifty big signs and symptoms and five hundred smaller ones can be adduced to prove their moral decadence. They have through lack of numbers alone forfeited their place as the leading European power, and have rendered impossible the establishment of a French Empire. Owing to this same cause their stationary 38,000,000 against Germany's 61,000,000 and 800,000 annual increase, they would if without allies lie at the mercy of their enemy. If Europe did not stand between her and her hereditary foe there can be no doubt France would be soon compelled to yield up her vast oversea possessions to which she has no men to send, and in which there is room for vast millions. Madagascar alone could take all Germany's increase. The climate in great part is suitable to Europeans. It is certain that England or Europe will not be able for ever to prevent the deserved spoliation of France by a more virile race; and it is certain that no power will prevent the British Empire from undergoing a similar fate if we do not become prepared to people our vast colonies, where there is room for our overflow for the next five hundred or thousand years. A correspondence now going in the *Times*, and contributed to by Australians of statesmanlike rank, makes clear that the facts are recognised. If we do not people these lands we shall in time lose them. The efforts of statesmen and the nation ought to be directed not to the restriction of population but to the solution of the social problem. A residium there may always be, but the numbers of the unemployable classes can be reduced by known methods; the physical, mental, and moral qualities of the people can be improved, and for every one of the unemployed a place can be found among kith and kin beyond the seas. A truly mighty British Empire can be built up only in this way; without an exuberant population, nothing can save it from destruction.

I am, Sir, yours truly,

Imperialist.

August 29th, 1906.

BELFAST.

[from our own correspondent.]

Belfast District Lunatic Asylum Annual Report.—Dr. William Graham's annual report is always an interesting document, as it deals not only with the questions of management and finance, but also with the increase of insanity and its probable causes in Ulster. The asylum population under his care has increased 37 last year, from a total of 1,071 to 1,108. The first cause of the increase is attributed to the greater comfort of the modern asylum, the recognition of this bringing a larger number of cases of senile insanity, no less than 25 admissions having been over 65 years of age. The cases of congenital mental deficiency also increased, and Dr. Graham looks forward to a still greater increase when the Royal Commission on the Care and Control of the Feeble-minded reports. As regards the supposed general increase of insanity, he does not seem to think that it has much to do with the "increased pressure of modern life," and such causes as are often connected with it. He points out that the intellectual classes furnish the smallest proportion of cases, and that his patients come mainly from the very poor, among whom bad food, alcoholic indulgence, and vicious moral environment play a sinister role. The question of the part played by alcohol is touched upon, and Dr. Graham is evidently inclined to look on alcoholic indulgence more as an early symptom of unstable mental equilibrium than as a great cause of insanity. The part of the report dealing with the prevention of insanity is most interesting, and the suggestion is made that it would be a good thing to get rid of the word "asylum" with its old associations of some transcendental causation for insanity, and use some such term as "hospital for brain diseases." In one thing, and one only, Dr. Graham sees hope, and that is the spread of education, and specially the spread of the knowledge of elementary physiology, which will prevent the marriages from which the mentally unsound are derived. He may be right, but we fear that while "Love laughs at locksmiths" he will also laugh at professors of physiology.

OBITUARY.

DR. E. T. WHITAKER OF SHREWSBURY.

The death occurred last week at White Lodge Shrewsbury of Dr. Edmund Thomas Whitaker, medical officer to public bodies at Shifnal, Oakengates, Wellington, Ellesmere, Cleobury Mortimer and Burford, Salop. He held similar appointments at Tenbury and Rock, Worcestershire and also advised the Denbighshire and Montgomery County Councils. He was keenly interested in all public health matters. Dr. Whitaker was an ardent student of Esperanto and did much towards forming a branch of the Esperanto Society amongst British medical men. He was a son of Dr. Edmund Whitaker, of Bacup, and obtained his M.B. and C.M. degree at Edinburgh University in 1894 and the D.P.H. Cantab. in 1896.

EDWARD JAMES ADKINS, M.R.C.S., Eng.

We regret to note the death of Mr. Edward James Adkins, son of the late Mr. J. E. Adkins, surgeon, of Yealmpton, who died on the 19th ult., æt. 53. The deceased was a popular and esteemed member of the Hastings medical profession. He had been in failing health for about two years, but his last illness only extended just a month. For some time he had been in partnership with Dr. W. E. Peck, and went to

Hastings from Yealmpton about twenty-four years ago. Deceased leaves a widow and family, the eldest son, Mr. Stanley Adkins, being at present in Canada. Deceased was educated at Guy's Hospital, whence he took the membership of the English College of Surgeons in 1875.

THOMAS PONSFORD CANN, M.D.DURH.

WE regret to note the death of Dr. Ponsford Cann, at the early age of 31. He was a native of Newhaven, and by his death the town has lost a prominent and highly respected inhabitant. As recently as 5th June last, the deceased's father died. Born in 1874, Dr. Ponsford Cann was educated at Durham University, where he graduated M.B in 1899, and subsequently acted as assistant to his father, who was also a medical practitioner. Since the latter's death he had carried on the practice at Newhaven, until about three weeks ago when he received a prick from an instrument while operating upon a patient—removing a tonsil. Pain in the finger was followed by unmistakable evidence of blood-poisoning, and despite everything that Dr. C. L. Brown and other medical gentlemen could do for him he died late on August 27th. He held many appointments in the district, including those of Medical Officer of Health to the Newhaven Urban District Council, to the Board of Alien Immigration, the Port of Newhaven and the Town, &c.

REVIEWS OF BOOKS.

DIAGNOSTIC METHODS (*a*).

THE University at Berne has in recent years established for itself in this country a well-earned reputation as a medical teaching centre. Until quite recently it was far more celebrated as a centre of surgical than of medical teaching, but since the work of Prof. Sahli has become known the honours have been more equally divided. Prof. Sahli is now justly recognised as one of the foremost teachers of clinical medicine on the Continent. It is now just twelve years since the first German edition of Prof. Sahli's book appeared, and during that time three subsequent German editions have been published. We must heartily congratulate Saunders and Co. for their enterprise in undertaking an English translation of the work, and thus making it more readily accessible to the practitioners of this country.

Though described as a text-book of diagnostic methods it is not, as Prof. Sahli points out, a mere compilation, and indeed a study of the work readily convinces one that the warning is unnecessary. There is much in the book that is quite new, and everything is treated with a directness that emphasises the personality and experience of the writer. It is not possible for us in the space at our disposal to pass in review the many excellent points in this work, and it will be sufficient if by the mention of one or two we induce our readers to study the work for themselves. We should like first to point out that almost every diagnostic method at the disposal of the clinician is here treated of, and its value appraised. Cystoscopy and the X-ray examination the author has omitted, not because he undervalues these methods, but because he has not had "sufficient practice and experience to justify the effort to teach them to others."

In judging of the value of a text-book of diagnostic methods we habitually first turn to the subject of auscultation for the way in which an author treats of this subject usually gives a very good indication of the value of his teaching. There is, perhaps, no subject in medicine which is so important for the beginner, and yet none which is suually so inefficiently explained. The student is bewildered with a number of long names, to none of which do two authors appear to attach exactly the same meaning. In the work before us the normal and abnormal sounds are clearly described, and the significance of the latter explained, but we cannot acquit the author of the charge of adopting an extensive and somewhat puzzling nomenclature, nor can we always agree with him in his explanation of the causation of the sounds. Though this is so, yet the descriptions are always admirable, and the reader is never for a moment left in doubt as to the author's meaning—which is much more than can be said in the case of most text-book writers. It must not for a moment be thought that we look on Professor Sahli's book as a mere text-book of diagnostic methods, or that its value is to be judged merely by its description of such methods; it is in reality much more, and its value largely depends on the admirable physiological and medical teaching which it contains.

A word of praise must be given to the translator, Dr. C. P. Flint, who appears to have done his work admirably, sacrificing neither the meaning of his author nor the decencies of the English language. We could wish the publishers had seen their way to make the book as easy to hold as it is to read, for while the matter would tempt us to study it in the arm-chair, the form compels us to sit at the table.

(*a*) "A Treatise on Diagnostic Methods of Examination." By Prof. Dr. Hermann Sahli, Director of the Medical Clinic, University of Berne. Edited with additions by Francis P. Kinnicutt, M.D., and N. Bowditch Potter, M.D. Authorised translation from the fourth revised and enlarged German edition. Philadelphia and London: W. B. Saunders and Co., 1906. Pp. 1008.

SHIPMASTER'S MEDICAL HELP. (*a*)

THE third edition of Mr. Johnson Smith's well-known manual of medical advice for shipmasters is before us, a proof in itself that the work is appreciated by the class for which it caters. Indeed except for the official *Ship-Captain's Medical Guide*, which constitutes part of the outfit of every ocean-going ship, we believe that Mr. Johnson Smith's book is the only one that seeks to guide the medically-minded skipper in his amateur ministrations to the crew. The lot of the seaman who falls dangerously ill on a ship which is not likely to see land for several weeks is one that is not pleasant to contemplate, and every ship's surgeon who has regaled himself on a long voyage with reading the official handbook will bear witness to there being many things medical not included in its philosophy. A book, then, that describes illness and injury with more care and detail should have a real field of usefulness, and such a book is this of Mr Johnson Smith's. It must have been a difficult one to write, for the average skipper's mental compass is not of the widest, and culture does not flourish a-shipboard. So that a great deal of writing down has to be done, if modern pathology is to be made acceptable to the mercantile marine brain. On the whole we think that Mr. Johnson Smith has "got there" more often than most medical writers would have done, and he has probably achieved his success through a sympathy with sailor men born of his large experience at Greenwich Hospital. His descriptions are generally simple, his explanations lucid, and his directions for treatment put no great strain on the intelligence. We remark with especial pleasure that he deals very gingerly with drugs, or rather advises his readers to do so, and that most of the advice as to the management of medical cases is confined to hygienic and nursing directions. His intention has evidently been to prevent the enterprising skipper from venturing too far into the perilous domain of therapeutics, and it is certainly a wise one. One is, therefore, surprised that it should be recommended (p. 233) that 10 drops of laudanum should be given every four hours in sloughing chancre in inflamed chronic ulcer (p. 213), and again (p. 89) in diarrhœa, without any indication as to how long such dosage should be continued, and surely it is hardly prudent to advise (p. 235) one grain of grey powder to be

(*a*) "A Medical and Surgical Help for Shipmasters and Officers in the Merchant Navy, including First Aid to the Injured." By William Johnson Smith, F.R.C.S., Principal Medical Officer, Seamen's Hospital, Greenwich. Third edition. Revised. 6s. London: Charles Griffin and Co., Ltd., 1905.

administered every four hours in primary syphilis, even though salivation be watched for. On page 115 we encounter a list of rather weird antiseptics, and whatever we may think of the rest it seems not without danger to include turpentine without mentioning its other properties. The directions for disinfecting (p. 21 and 22) are a little antiquated in view of modern practice, and we note (p. 25) that a drachm is said to contain forty drops. In the Board of Trade scale of medicines and medical stores reproduced, it is stated that all the drugs in the list marked with an asterisk should be supplied with a red poison label. We see that carbolic acid and Pil Sapornis Co. are not so marked; and we think that this omission should be rectified. That, however, is a matter for the Board of Trade, and not for the author who merely reproduces their scale. We are glad to learn that the St. John Ambulance Association are making special efforts to attract officers and sailors to their classes, and such as do so will be glad to find in this volume some amplification of their lessons. On the whole the book is so good that we should be glad to see it made official by the Board of Trade, and we believe that doing so would be a distinct gain to the health and comfort of those that go down to the sea in ships.

MEDICAL ANNUAL AND INDEX. (*a*)

So well known and trusted by the profession that commendation of each periodic issue is unnecessary. The present volume is as good as any of its predecessors, and the contributors have in the main managed to combine a comprehensive view with a selective judgment. With such a variety of authors it would, of course, be impossible to expect a uniform literary style, but more careful editing might have avoided such "howlers" as "to onset" (page 548). The plates are so scanty that they might as well have been omitted A series of 16 stereoscopic plates—excellent as they are—to illustrate the radical mastoid operation shows a lack of a proper sense of proportion. There is a considerable difficulty in finding one's way through the volume, a serious drawback to any book for ready reference, and it is unpleasantly weighted with advertisements. We make these suggestions not in any captious spirit, but in the hope of rendering more useful future issues of a book already invaluable.

The present volume is closely followed by the "Synoptical Index" (*b*) for 1899-1904. The book is extremely convenient as a guide to the annual volumes, while it gives in the briefest form an enormous amount of valuable information under each heading.

WATERSTON'S STEREOSCOPIC ATLAS. (*c*)

PARTS IV and V more than maintain the reputation of this most interesting and original work. Part IV includes 51 views, of which 25 have been devoted to the upper limb and 16 to perineum and pelvis. The remaining 10 have been prepared from special dissections to show the lumbar region and the position of the viscera of the thorax and upper part of the abdomen from behind. The latter series should be of interest to every physician, who will also find simply invaluable reference material in the localisation areas of the brain, as figured and mapped out in Part V. Much of the physiology and pathology of the nervous system is necessarily abstract, but the learner will find in Waterston's stereoscopic views a graphic map of the intricate field he is exploring. The demand for this series by teachers and students of medical matters, whether qualified or unqualified, is sure to be great. We congratulate both author and publishers upon the way in which this laborious and monumental work has been carried out to the standing credit of British medical literature.

(*a*) "The Medical Annual; A Year-book of Treatment and Practitioner's Index," 1906. Twenty-fourth year. Pp. lxxxiii. 648. Price 7s. 6d. net. Bristol: John Wright and Co.

(*b*) "Medical Annual Synoptical Index to Remedies and Disease For six years 1899-1904. Pp. iv. 279. Price 7s. 6d. net. Same publishers

(*c*) "The Edinburgh Stereoscopic Atlas on Anatomy." David Waterston, M.D., F.R.C.S.E., Lecturer on Anatomy. University of Edinburgh. E. C. and E. C. Jack, Edinburgh and London. 1906.

THE COMBINED TREATMENT IN DISEASES OF THE EYE. (*a*)

IN this small book Dr. Burnham gives us the details of what he calls his combined treatment of disease. It consists of the administration of mercury and iodide of potassium internally with sub-cutaneous injections of pilocarpine. The author relates many cases in which he got good results from the treatment. They included rheumatic, syphilitic and gonorrhœal diseases of the iris and ciliary body, various forms of kirato-iritis and cyclitis, calcareous degeneration of the cornea, corneal opacities, conical cornea and sympathetic ophthalmia.

As there are many niceties in the administration of the treatment, which the author insists upon, those who think of trying the combined treatment are recommended to consult the original.

RUHRAH'S DISEASES OF CHILDREN. (*b*)

THIS is a remarkably concise little volume dealing with a wide subject. The method adopted by the author is to treat each subject with systematic notes, which are fuller in the more important maladies. In this way the reader is furnished with a compact guide which is at the same time trustworthy and well informed. There are a number of good illustrations. The publishers may be congratulated on having produced an excellent hand-book for students and practitioners.

INJURIES TO THE NOSE, AND ITS ACCESSORY CAVITIES. (*c*)

THE book under review contains in all some 130 pages, and the author has collected a good many cases to illustrate the various accidents. The book is divided up so as to be easy for purposes of reference, and has headings in the margins, a point which might well be copied in medical works. After fully describing the signs and symptoms of the various injuries he details several operations and methods of treatment in each of the different classes. The last chapter is devoted to the consideration of the insurance question, and what prognosis should be given as to ultimate deformity and what likelihood there might be of danger to life or total disablement. The book can be recommended as useful for reference in any case where difficulty may be experienced in deciding as to the best form of treatment.

AN outbreak of typhoid has occurred at Pontypool the cause of which is at present obscure. The various water supplies have been analysed, and notices issued urging the public to boil all milk and water, and to use the greatest care as to the cleanliness of the receptacles in which they are kept.

SAMUEL TANSLEY, a sorter at the Northern District Post Office, Upper Street, Islington, was fined £5, at Uckfield last week, for exposing his child without proper precautions when she was suffering from diphtheria. He was in the neighbourhood on a holiday.

DEDUCTING deaths of infants which were to a large extent not preventable, Dr. Reginald Dudfield, the borough medical officer of health, considers that 197 lives were locally last year "wasted." "Much of this wastage," he adds, "is due to carelessness and ignorance, and ought to be obviated."

(*a*) "The Combined Treatment in Diseases of the Eye." By G. Herbert Burnham, M.D., Tor., F.R.C.S.Edin., M.R.C.S.Eng., Professor of Ophthalmology and Otology at the University of Toronto, Original Member of the Ophthalmological Society of the United Kingdom, Oculist and Aurist to the Mercer Eye and Ear Infirmary, and General Hospital, &c., Toronto, Canada. Pp. viii. and 92. Cr. 8vo. Price 3s. London: H. K. Lewis, 136, Gower Street, W.C. 1906.

(*b*) "A Manual of Diseases of Children." John Ruhrah, M.D. Baltimore: Saunders and Co., Philadelphia and London, 1905.

(*c*) "Die Verletzungen der Nase und deren Nebenhohle." Von Dr. Friedrich Ropke. Wiesbaden: J. F. Bergmann, 1905.

MEDICAL NEWS IN BRIEF.

National Federation of Meat Traders' Associations.

THE biennial meeting of the National Federation of Meat Traders' Associations was held last week at Newcastle-on-Tyne, under the presidency of Mr. R. H. Brechin, Glasgow, who said that the question of direct Parliamentary representation had been considered, but it was thought that further consideration should be adjourned to the annual meeting. Mr. W. Coggan moved that, having regard to the fact that, pending the issue of the report of the Royal Commission on Tuberculosis, the Government emphatically declined to promote or facilitate legislation in relation to the seizure and confiscation of the carcases of animals alleged to be tuberculous, the federation would most respectfully urge upon the Government the necessity for issuing forthwith the report of the Royal Commission, in the interest of master butchers throughout the kingdom, who were suffering the most serious loss and inconvenience. He said that if there were no danger from boiled milk, surely there could be none from roasted meat. There was not a single case in which a medical man could say that consumption was brought on through eating tuberculous meat. They had thus a good deal to urge against the losses to which they were subjected. Mr. D. Rose, of Birmingham, seconded the motion, which was carried. It was resolved to oppose the Public Health (Regulations as to Food) Bill and Lord Donoughmore's Public Slaughterhouses Bill. In a discussion on Sunday trading, the feeling of the meeting was against opening butcher's shops on Sundays. Uniformity in swine removal orders was also urged.

An Overdose of Laudanum.

MR. BERNARD REECE, Cardiff deputy-coroner, held an inquest on Wednesday last on the body of Isaac Jones (30), who died as the result of poisoning on the previous Monday night. William Jones, deceased's brother, said he saw the deceased a fortnight ago and again just before his death. He was on the former occasion in "extra good spirits," and witness had never heard him threaten to do away with himself. He had heard that his brother was in the babit of taking drugs and that he had suffered of latc from influenza and pains in the head. Mrs. Orchard, an aunt of the deceased. and also his landlady, said deceased went to his work 8 about 7.15 a.m. on the Monday, and returned about a.m. He told her that he had had "the sack," and he seemed upset. Witness went up about 4.15 o'clock, and found him unconscious. She then sent for a doctor and the police, and he died about 8 p.m. the same night. The bottle and tumbler produced were found in a drawer in his room. She did not know that he had been in the habit of taking drugs. James Murray, manager of a chemist's shop in Bute Road, said he served deceased with half an ounce of laudanum for toothache. Dr. Buist: There is no restriction in law, but don't you think it an improper thing to supply a man with such a quantity?—Certainly not. Dr. Buist: Well, I do, and I think it a serious matter. Dr. Buist in his evidence said he found deceased in an advanced state of coma, and antidotes were administered. Half an ounce of landanum contained sixteen grains, and a full medicinal dose was two grains. Death was due to laudanum. The jury returned a verdict of "Death from misadventure, owing to taking an overdose of laudanum."

Fleetwood Camp—Another Death from Enteric Fever.

ANOTHER officer—Captain G. R. Fitzgerald, of the 5th Battalion Royal Munster Fusiliers—has died from enteric fever contracted in the camp of the 3rd (Militia) Battalion Loyal North Lancahsire Regiment at Fleetwood. A few days before the camp broke up three or four officers became ill. Lieutenant Rix died in the bospital at Fleetwood on Saturday night. The attacks of the fever were confined exclusively to the officers' quarters. Not one of the men of the battalion was affected—indeed the camp was a most healthy one. It is generally agreed by those who have been making inquiries into the matter that either the food or the water was contaminated. The food has been found to be quite wholesome, and it is now stated that a temporary water-pipe was run up from the town main to the officers' mess and that this pipe is defective. Several leakages were found, and as the pressure was intermittent, it is possible that the sub-soil penetrated into the pipe. The War Office are understood to be responsible for the laying of the pipe. Then, besides this defective pipe, another possible cause may have been the use of one of the old-fashioned army water-carts, which was issued from the depot for the purpose of storing water for culinary purposes. It is suggested in some quarters that it was possibly used in South Africa.

L.C.C. and Consumption.

"An interesting medical departure is to be made by the London County Council medical officers when the London elementary schools reassemble after the summer holidays. To test the accuracy of statements that have been made as to the prevalence of consumption among London school children all the children in certain selected schools are to have their chests examined and to be measured and weighed. In view of the possibility of parental objections, the parents of all the children in these schools are to be asked to give their consent to the examination."

Whooping Cough Microbe.

THE microbe of whooping cough has, it is said, been discovered and cultivated by Drs. Bordet and Genjou, of the Pasteur Institute at Brabant, and it is hoped that a cureative serum will be found within a very short time. Professor Metchnikoff, of the Pasteur Institute, is delighted at the success of these two disciples of the great Pasteur. "I am all the more pleased," he said, to an interviewer, "that Dr. Bordet has been successful for the reason that he worked under me from 1894 to 1901. As to the practical results of their discovery, I hear that these have already been most encouraging. Whooping cough can now be diagnosed in the most certain manner, a thing which was not possible formerly Only the method requires to be carried out by a skilful bacteriologist. However, a simplified method will certainly be discovered in time, and what is more important, we shall find the serum, which will enable practitioners all over the world to cure a disease from which almost every child suffers during its early years."

Consumption in Germany.

Two years ago, an inquiry and consultation office was established at Berlin, with the object of giving advice gratis to persons afflicted with consumption. The report of this office for the past year has just been issued. Six physicians and eleven sisters attended the office ten times weekly; 15,661 persons were examined medically; and in addition, 18,644 visits were made to dwellings, 365 beds were granted, 2,765 persons were helped with their rent and in other ways, for purposes of observation, 804 persons were placed in hospitals, 622 children were sent to children's hospitals, 1,000 more to homes in the woods or other suitable places, and 8,200 dwellings where consumption had set its roots were rendered sanitary. The Bureau, altogether, spent something like 500,000 marks in its remarkable work of charity.

Infantile Mortality.

The Annual Report of Dr. D. J. Thomas states that at Acton the public health generally has been good, and the death-rate lower; indeed, only two London boroughs have a lower death-rate. Infantile mortality has been substantially reduced, thanks to the good work done by the lady health visitor, Miss Williams, the improvement being in the decrease of deaths between the age of three and twelve months.

Suspected Cholera in Berlin.

Uneasiness has been caused at Berlin by the death of a girl, eight years old, who is suspected of having died of Asiatic cholera. The body has been taken for examination, and her relatives have been carefully isolated. The child lived in one of the most insanitary districts of Berlin.

The Roumanian Leper.

The Roumanian who is afflicted with leprosy, and who was sent back to Frankfurt, is being carefully treated in the Frankfurt Hospital, and kept strictly isolated. Negotiations are on foot to have him transported back to England. It is said he acquired the terrible disease in Abyssinia, where he was at work on the railway. He is a gifted man, and speaks eight languages.

Epidemic at Toulon.

An epidemic of cerebro-spinal meningitis is raging among the military at Toulon, necessitating the evacuation of the barracks. Ten artillerymen succumbed this month, and numerous cases are in the hospitals.

Diptheria in Leicestershire.

The epidemic of diphtheria which has been playing such havoc in the village of Fleckney, Leicestershire, for the last three months, has now spread to neighbouring towns and villages. Cases have broken out in Market Harborough, Kibworth, Harcourt, and Medbourne. An inspector of the Local Government Board has visited the district, and every precaution is being taken to stamp out the disease. A house to house visitation is being made at Fleckney by Dr. Robinson, county medical officer, and Dr. Phillips, medical officer of health for the district, and in all suspicious cases injections of antitoxin are being made.

Scarlet Fever at Hyde.

An outbreak of scarlet fever of a serious type has occurred at Hyde. There are over seventy patients in the hospital. It is said that cases have occurred in homes to which children have been sent back after treatment at the hospital, and, in reply to a question on the subject at a meeting of the Council, Mr. Alderman Kenny said it was impossible to tell definitely when a patient was absolutely free from scarlet fever or from danger of infecting others, but every possible precaution was taken to avoid sending a child home before danger of further infection had disappeared.

Typhoid at Pontypool and Panteg.

For twenty years there had been little zymotic disease in the area of the Pontypool and Panteg Councils, particularly typhoid fever. However, in May of this year several cases of typhoid were notified, and since then over thirty cases have been notified in Pontypool. Sixteen cases are also reported in the Griffithstown district, two of which have since proved fatal. Up till the present every effort to trace the origin of the outbreak has failed. Samples have been taken of milk and water, and these have proved satisfactory. In the Panteg Council's area Dr. Essex and Dr. Mulligan have visited a number of cases, and are of the opinion that the water was the only factor in common to all the cases, and of this samples are being taken. At a meeting of the Council the members were of opinion that the water from the Penyrheol reservoir should be shut off, stating that it was very thick.

Registrar-General's Returns.

The deaths registered last week in seventy-six great towns of England and Wales corresponded to an annual rate of 14·6 per 1,000 of their aggregate population, which is estimated at 15,818,360 persons in the middle of this year. In the preceding three weeks the rates had been 12·0, 12·6, and 13·8. Table 1 of the Return shows, for the several towns, the death-rates in each of the last four weeks: it also shows for the week ended last Saturday the births, the deaths from several causes, and the death-rates from certain epidemic diseases.

Measured by last week's mortality, the highest annual death-rates per 1,000 living, were:—From all causes, 20·3 in Middlesbrough, 20·4 in Birkenhead, 20·6 in St. Helens, 21·2 in Salford, 22·0 in Hanley, and 23·0 in West Ham; from measles, 1·3 in Norwich, 1·6 in Huddersfield, 1·9 in South Shields, 2·5 in Burnley, and 3·6 in Salford; from whooping-cough, 1·6 in in Middlesbrough and 1·8 in Birkenhead; and from diarrhœa, 5·1 in St. Helens, 6·0 in Wigan, 6·2 in Birkenhead, 6·6 in Nottingham, 7·6 in Aston Manor, and 10·2 in West Ham. One death from small-pox was registered in Liverpool, but none in any other of the seventy-six towns.

In London 2,155 births and 1,352 deaths were registered. Allowing for increase of population, the births were 250 and the deaths 151 below the average numbers in the corresponding weeks of the previous four years. The annual death-rate from all causes, which had been 11·6, 11·7, and 14·0 per 1,000 in the preceding three weeks, further rose last week to 14·9. The death-rate in the four weeks ended last Saturday averaged 13·1 per 1,000, being 2·0 per 1,000 below the mean rate in the corresponding periods of the four years 1902–5.

According to returns from the Metropolitan Asylums Board and from the London Fever Hospital there were 3,051 cases of scarlet fever, 851 of diphtheria, and 101 of enteric fever under treatment in these hospitals on Saturday last (Table 3). The admissions during the week, as compared with those in the preceding three weeks, were as follow:—Of scarlet fever, 308 cases, against 413, 408, and 415; of diphtheria, 100 cases, against 140, 135, and 133; and of enteric fever, 7 cases, against 18, 17, and 26. Table 10, compiled and furnished by the Medical Officer of Health of the Administrative County of London, shows the number of cases of Infectious Disease that were notified in the County during the week ended August 4th, 1906.

Notification of Births.

The St. Pancras Borough Council have just issued a notice in which they state that they have resolved to adopt tentatively during three months a system of voluntary notifications of birth, and to pay to the father doctor, midwife, student, or other person attending upon the mother the sum of 1s, for notifying to the medical officer at the Town Hall, Pancras Road, the birth within 48 hours of its occurrence in the borough.

Death from Lead Poisoning.—The Borough Coroner, held an inquest at Hanley, on August 14th, on the body of John Marlow æt. 49, gloss placer, Cannon Street. It was stated that deceased had not been able to work since March last, and had been attended by two doctors. It had been known that he suffered from lead poisoning for a year or two, and he had taken medicines to secure relief. Medical evidence after *post-mortem* examination showed that death was due to disease of the kidneys, caused by lead poisoning, and the jury returned a verdict to that effect.

A fish merchant, charged at Yarmouth with attempted suicide was on August 16th stated by Dr. John Rollings, house-surgeon at the hospital, to have taken a larger quantity of oxalic acid—one ounce—and survived than there was any mention of in medical records of poison cases. The doctor also said that Smith undoubtedly owed his life to the promptitude of his sister, who instantly gave him salt and water. For days Smith, in a collapsed condition, had hovered between life and death, being only kept alive by injections of stimulants, his throat being closed.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS. ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT LITERATURE OF PHYSIOLOGY AND PATHOLOGY.

Absorption in the Large Intestine.—Most of the text-books of physiology teach us that almost the entire absorption of foods takes place in the small intestine, the large intestine absorbing little beside water. Mingazzini in 1900 carefully described the microscopic appearances in the cells of the villus during functional activity of absorption, the most noticeable feature being a collection of globules at the base of the epithelial cells, these globules afterwards finding their way into the veins of the villus. Bremer (*Journal of Medical Research*, July, 1906) describes exactly similar changes as taking place in the epithelial cells of the large intestine. The only difference as to the function of absorption between the small and the great intestine, he believes, is one of degree. He has observed the same cycle of events in each case—both spherule formation and ingestion by leucocytes. The process goes on both in the epithelium of the surface and in that of the glands, but is inhibited if excessive activity of the mucous glands occur. Bremer supports his description by excellent plates. R.

The Mechanism of the Closure of the Bladder.—Leedham-Green (*British Medical Journal*, August 11, 1906) publishes some observations intended to combat the current or Finger's theory of the mechanism of the closure of the bladder. Finger held that when the bladder becomes much distended, the pressure of the fluid gradually causes the neck of the bladder and the internal sphincter to yield, allowing the fluid to enter the posterior urethra. When this takes place, the sharply defined border between the bladder and urethra disappears, and a bladder neck is formed. Leedham-Green, having criticised the reasons which led Finger to adopt this view, gives certain skiagraphs of bladders containing metallic fluids. In all of these the shape of the bladder is globular or oval, never pear-shaped, suggesting that no bladder-neck is formed. The skiagraphs cannot be said to be conclusive, since it is not quite clear that they were taken in such positions as would render the bladder-neck, if present, evident. According to Leedham-Green the muscular control of the bladder rests almost entirely in the internal sphincter, which, in opposition to the ordinary view, he regards as a voluntary muscle. R.

Cholera Toxin and Antitoxin.—Brau and Denier have devoted careful study to the subject of the toxin and antitoxin of cholera (*Annales de l'Institut Pasteur*, July 25, 1906). When Metchnikoff and Rux published their original memoir on the toxin of cholera, a debate at once sprang up as to whether the toxin was intracellular or freely soluble. The present paper throws light on this, as on some other obscure points. The main conclusions arrived at are:—(1) In liquid media the cholera vibrio rapidly produces a soluble toxin. (2) The production of the toxin is associated with destruction of the vibrios. (3) This toxin is very active on injection into the veins, giving rise to a marked production of antitoxic bodies. (4) Venous injection with live cultures gives rise to a more marked production of antitoxins. (5) No distinction can be drawn between the toxin contained in the bodies of the microbes and that obtained in the liquid of the culture tubes. R.

A Cytolysin for Nerve Fibres. — Following on Bordet's discovery of the phenomenon of hæmolysis, various other forms of cytolysis have been described by various observers. To the list of bodies subjected to this process, Schmidt has now added medullated nerve fibres (*Annales de l'Institut Pasteur*, July 25, 1906). He employed for his experiments the sciatic nerves of frogs, injected into guinea-pigs. The nerves were prepared for injection by chopping into small pieces and pounding in a mortar with physiological salt solution. Schmidt found (1) that the repeated introduction of the emulsion thus obtained into the peritoneal cavity of guinea-pigs produced in the serum of the latter certain bodies possessed of a destructive action on the nerves of the frog. (2) This action shows itself after subcutaneous injection in the frog of the serum of the guinea-pigs thus treated, by disorders of locomotion, and histologically by marked changes in the medullary sheath, by multiplication of the nuclei of Schwann's sheath, and by breaking up of the axis cylinder. (3) The serum produces agglutination when mixed with the emulsion of peripheral nerves. (4) Some time after the introduction of the emulsion to the peritoneal cavity of the guinea-pig one no longer finds free particles of myelin, as they are all englobed by the leucocytes. R.

Regenerative Processes of the Liver. — Pearce describes (*Journal of Medical Research*, July, 1906) the process of repair of local necroses of the liver produced in dogs by the injection of hæmagglutinative sera. The phenomenon is of special interest in that the lesions are caused by an agent reaching the liver through the circulation, and is therefore comparable to acute yellow atrophy and other toxic necroses in man. The first evidence of repair is the occurrence after thirty-eight hours of mitotic figures in the liver cells. At the end of the second day these have increased, and a considerable proliferation of endothelial cells has occurred in and about the necrotic areas. These latter tend to encapsule the necrotic cell fragments. During the following three or four days, while these processes advance, the necrosed tissue is largely replaced by granulation tissue. There is some evidence that quite small areas of necrosis, involving only a few cells, may be replaced by proliferation of liver cells, without the formation of connective tissue, but in all areas of appreciable size the latter is a prominent feature. Later, however, the connective tissue is, to a great extent, replaced by liver cells, only the coarse bands remaining. The great power of the liver cells to increase by indirect division is a striking feature throughout the whole process. Many multinuclear and giant liver cells are observed in the zone between the normal liver substance and the necrosed patches. New bile ducts aid, by a transformation of their cells into liver cells, in the restoration of the liver tissue. R.

Trypanosomiasis in Man and other Animals.—Tobey (*Journal of Medical Research*, July, 1906) gives the history of our knowledge of trypanosomiasis, and an enumeration and description of the various forms of trypanosomes, and the diseases they cause among different animals. (1) *Fishes.*—The list of fishes in which trypanosomes have been found is a long one, including the carp, the tench, the bream, the eel, the sole, the dog-fish, and the minnow. (2) *Amphibia.* Frogs are very subject to trypanosomiasis, various forms of the organism having been observed. (3) *Reptiles.* Trypanosomes have been seen in both snakes and turtles. (4) *Birds.* Many common birds are subject to trypanosomal infection—*e.g.*, blackbirds, robins, sparrows, pigeons. (5) *Mammals.* Rats in all parts of the world are found to be infected with the trypanosome first described by Lewis in 1877. Horses suffer from five well known trypanosomal diseases—nagana, surra, mal-de-caderas, dourine, and Gambian horse-sickness. Some of these diseases also

affect other mammals. Cattle in the Transvaal suffer from "galzeikte," a trypanosomal disease, which is not known to affect any other animal. In man, as is well known, sleeping sickness is due to a trypanosome. R.

Physiology of the Peritoneum. — Clairmont and Haberer ("Arch. für Klin. Chir.," Bd. 76, H. and L.) have made numerous experiments on the absorptive properties of the peritoneum and have arrived at some important results. The method of examination consisted in examining the urine at intervals after intra-peritoneal injections of potassium iodide. They found in the first place that the absorptive powers were unfavourably influenced by simple laparotomy and also by eventeration, the latter having a more marked effect than the former. Prolonged washing with warm physiological salt solution diminishes the unfavourable effect, and increase in the abdominal pressure or inflation with air has a similar beneficial effect. On the other hand absorption is much retarded during ordinary narcosis, and by morphine or physostigming injections. During the first stage of inflammation absorption is distinctly accelerated. Therapeutically their most important observation is the fact that washing out of the cavity is the most judicious prophylactic means at our disposal to ward off general peritonitis in operation cases, whether the peritoneum itself be normal or inflamed. M.

Congenital Laryngeal Atresia.—Frankenberger ("Virchow's Archiv." Bd. 182, H. 1), draws attention to the fact that congenital stenosis of the larynx has only rarely been described and that actual atresia is so rare as to be almost unknown. Hitherto four cases in all of the latter condition have been reported, and to this the author now adds a fifth. In the larynx of a still-born child he found on each side, in the place of the arytenoid cartilage, a large cartilaginous nodule standing out very prominently under the mucous membrane. The vocal cords were developed, but the rima glottidis was completely obliterated, so that it was impossible to enter the larynx even with the finest sound. The trachea itself, however, was patent. Histological examination did not reveal any trace of old inflammation. The epithelium was cylindrical and the mucous membrane normally developed. Mucous glands were absent at the actual site of adhesion, and in this place the blood-vessels were especially numerous. The actual binding tissue was partly connective and partly muscular in nature. M.

Influence of High Altitudes on General Nutrition.—Guillemard and Moog ("Compt. Rend. de l'Acad." T. 141, p. 843) have investigated the condition of their urine at Paris, Chamonix, the Grand Mulets, and at the summit of Mont Blanc. They found that the general quantity of the urine and also the mass of its ingredients were much reduced during their first few days at a high level; but that a gradual increase ensued, so that the normal was reached about the sixth to the eighth day. Both organic and inorganic constituents were retained, the latter in greater quantity than the former. There was no definite parallel between the total urea and total solids excreted, and the uric acid showed no characteristic change. Cryoscopic examination showed a lessened molecular concentration and the presence of intermediate metabolic products. M.

Parotid Secretion in Man. — Two cases of parotid fistula gave Zebrowski ("Pfluger's Archiv.," Bd. 110, H. 3 and 4, S. 105) the opportunity of studying the reaction of this gland to various food stuffs. After three months' study he has come to the conclusion that it is really irritating substances and the irritating qualities of substances which principally call forth the secretion. This leads the writer to deny to some extent Pawlow's doctrine, of conformity of quality and amount of secretion to the quality and quantity of food taken, but not *in toto*, for he finds that the alkalinity of the secretion becomes enhanced when acids are given and that the ferment strength becomes greater in proportion to the amount of organic substances in the food. He also finds that dryness of food leads to an increase in secretion, and that there is a considerable increase in quantity of saliva poured out, and a very considerable alteration in its properties corresponding to the quantity of the various foodstuffs administered. The alkalinity and ash content, the ferment power and the amount of organic material present in the saliva are directly related. M.

Digestion of Proteid in the Stomach. — Lobler has investigated this matter in dogs by making a duodenal fistula as near as possible to the pylorus, and introducing a metallic cannula into the intestine as described by Pawlow. When the preparations were complete 100 grammes of flesh were given to the dogs, and the appearance of acid juice in the cannula was awaited. As soon as the first drops appeared, the upper part of the intestine was severed from the duodenum, and a button was placed in the last named, so that all the stomach contents were discharged through the cannula. A portion of the digestive products from the stomach was also injected from time to time into the distal end of the severed intestine. The first point determined was that the discharge of the early digested products took place almost immediately after the exhibition of the food, and flowed out from the stomach in a thin fluid form. The periods of discharge followed rapidly, and were interrupted by regular reflex closures of the pylorus, each closure period of the pylorus tending to lengthen as digestion proceeded. Of the food given only 20 per cent, remained undissolved. The dissolved albumin consisted at the end of stomach digestion of 80 per cent. pepsine and 20 per cent. albumin; and of this between 20 per cent. and 30 per cent. was absorbed within the stomach itself. M.

Primary Sarcoma of the Spleen.—Daddi reports (*Rivista Critica di Clin. Med.*, 1905, No. 48) a case of primary sarcoma of the spleen which he considers of interest both from its rarity and from a diagnostic point of view. It occurred in a man æt. 64, whose illness began with sudden pain in the left hypochondrium, and a swelling was soon noticed in that position which was regarded as an enlarged spleen. The swelling persisted, the patient grew weak and emaciated and died about two months later with the symptoms of general peritonitis. The blood examination had shown diminition of hæmoglobin, diminution in the number of red cells, and a normal white cell content, except during the last few days, when there was a neutrophile leucocytosis accompanying the peritonitis. As a result of the blood-count, leukæmia and Hodgkins' disease were excluded during life, and so also was malaria, and inasmuch as the blood resembled what is found after extirpation of the spleen it was concluded that a malignant tumour was present destroying the function of that organ. At the autopsy a typical sarcoma of the spleen was found with secondary nodules in the stomach and intestinal walls. M.

Experimental Cirrhosis of the Liver. — Pearce has injected dogs (*Albany Med. Annals*, 1906) with the blood serum of rabbits, which had been previously subjected to repeated injections of red corpuscles obtained from dogs. When the serum was injected into the femoral vein or into the peritoneal cavity necrotic areas of smaller or larger extent were formed. Most of the animals experimented with died at once, but in the few that survived it was possible to observe that the necrotic areas gradually underwent regeneration. After some little time very numerous mitotic division figures were visible in the necrosed parts, or these parts were invaded and finally completely replaced by connective tissue. The final result after about thirty days was a general hardening of the liver with granulation of the surface, and with general cirrhosis. Pearce claims to have been the first to demonstrate liver cirrhoses produced in this manner and to have observed their development. The type of cirrhosis, however, is very different from that found in man. M.

NOTICES TO CORRESPONDENTS, &c.

☞ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to 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 proofs.

CONTRIBUTORS are kindly requested to send their communications if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

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.

M.D. (Oxford).—With regard to your query re a small flat or rooms in West Central London we know that you will not get what you want under £100 or £130 per annum.

LEGISLATION ON ALCOHOL, DRUGS, &c.

VICTORIAN.—New regulations have just been passed by the Victoria Board of Health. One deals with the amount of alcohol contained in patent medicines, and the other prohibits the sale of preparations containing certain specified drugs, unless the presence of the same is notified on the label; preparations containing more than 10 per cent. of spirit are to be sold as alcoholic compounds. The regulations come into force on October 1, and are independent of the regulations imposed by the Federal Commerce Act.

DR. G. (Ramsay).—With regard to the relation between atmospheric conditions and the occurrence of cerebral hæmorrhage, temperature in itself has not been shown to exert any influence, though cases have been slightly in excess on days with a rising thermometer and increased atmospheric pressure.

LEGAL.—We hear the Mayor of Otley has supplanted the dirty covers of the Testament by celluloid ones, which can be easily washed after being kissed by witnesses.

"BY A PHYSICIAN."—You are quite right about the erroneous matter in some of the articles thus signed in the lay papers. They manage better in New York, where the medical portion of the journal is conducted by leading doctors, who write on questions which may advantageously be thought about by the laity.

DR. M. (Hampstead).—Such impostors are not rare in consulting rooms. They generally give the name of another doctor as reference. A good test is to say you will telephone to the one mentioned at once. In one instance this had the effect of making the man hurry out of the house.

Vacancies.

Royal Dental Hospital of London (School of Dental Surgery), Leicester Square, W.C.—Demonstrator of Practical Dental Surgery. Salary £100 per annum. Applications on or before Monday, September 24.

Egyptian Government.—Ministry of Education.—Professor of Midwifery and Gynæcology. Salary £400 a year, with private practice. Applications to the Director, School of Medicine, Cairo, Egypt.

Egyptian Government.—Ministry of Education.—Medical Tutor and Registrar to Kasr-El-Ainy Hospital. Salary £400 a year. No private practice. Applications to the Director, School of Medicine, Cairo, Egypt.

Metropolitan Hospital.—Casualty Officer. Salary £150 per annum. Applications to Charles H. Byers, Secretary and House Governor.

Manchester University.—Junior Demonstrator in Physiology. Salary £100 per annum. Applications to the Registrar.

Sussex County Hospital, Brighton.—House Surgeon. Salary £100 per annum, with board and residence in the hospital, with washing. Applications to the Secretary.

Royal London Ophthalmic Hospital (Moorfields Eye Hospital), City Road, E.C. Founded 1804.—Senior House Surgeon. Salary £100 a year, with board and residence in the hospital. Applications to the Secretary.

Camberwell House Asylum.—Second Medical Assistant Officer. Salary £150 per annum, with board, apartments, and laundry. Applications to Medical Superintendent.

Royal Southern Hospital, Liverpool.—Resident Pathologist and Registrar. Salary £100 per annum, with board and residence. Applications to the Chairman of the Medical Board.

Kidderminster Infirmary and Children's Hospital.—House Surgeon. Salary £120 per annum. Applications to the Secretary.

City of Birmingham Asylum, Rubery Hill, near Birmingham.—Assistant Medical Officer. Salary £150 per annum, with furnished apartments, board, &c. Applications to the Medical Superintendent.

Southwark Union, London.—Third Assistant Male Medical Officer at the Infirmary, East Dulwich Grove, S.E. Salary £100 per annum, with board, lodging, and washing. Applications to Howard C. Jones, Clerk, Union Offices, John Street West, Blackfriars Road, S.E.

Appointments.

ATKINSON, E. L., M.R.C.S., L.R.C.P., Senior Obstetric House Physician to St. Thomas's Hospital.

ATTLEE, CECIL K., M.R.C.S., L.R.C.P.Lond., House Physician at the Evelina Hospital for Sick Children.

BIRCH, CHARLES, M.R.C.S., L.R.C.P.Lond., Medical Officer to Claysmore School, Pangbourne, Berks.

BROWN, W. L., L.R.C.P., L.R.C.S.Edin., L.F.P. and S.Glas., D.T.M. Lond., Assistant Anæsthetist to the Central London Hospital.

CLARKSON, F., M.B., B.S.Durh., Special Department (Ear), to St. Thomas's Hospital.

COATS, GEORGE, M.D.Glas., F.R.C.S.Eng., Additional Ophthalmic Surgeon to the Out-patient Department at the Great Northern Central Hospital, London, N.

COX, R. J. H., M.B., B.S.Lond., M.R.C.S., L.R.C.P., Resident House Surgeon to St. Thomas's Hospital.

CUNNINGHAM, N. R., M.R.C.S., L.R.C.P., Resident House Physician to St. Thomas's Hospital.

DICKSON, A. N., M.R.C.S., L.R.C.P., Resident House Physician to St. Thomas's Hospital.

DUNKLEY, E. V., M.B., B.S.Lond., M.R.C.S., L.R.C.P., House Physician to Out-patients to St. Thomas's Hospital.

ECKENSTEIN, K. E., M.R.C.S., L.R.C.P., Children's Surgical, to St. Thomas's Hospital.

EYRE, C. R. B., M.R.C.S., L.R.C.P., Junior Obstetric House Physician to St. Thomas's Hospital.

GAMLEN, R. L., B.A.Cantab., M.R.C.S., L.R.C.P., House Surgeon to Out-patients to St. Thomas's Hospital.

GOTZLEE, H. E., M.R.C.S., L.R.C.P., Senior Ophthalmic House Surgeon to St. Thomas's Hospital.

GRAY, H. T., M.A., B.C.Cantab., M.R.C.S., L.R.C.P., Special Department (Throat), to St. Thomas's Hospital.

HEWETT, F. S., B.A.Cantab., M.R.C.S., L.R.C.P., Resident House Surgeon to St. Thomas's Hospital.

HOOKER, A. W., M.B., B.S.Lond., M.R.C.S., L.R.C.P., Junior Casualty to St. Thomas's Hospital.

HOWITT, A. B., M.A., M.B., B.C.Cantab., M.R.C.S., L.R.C.P., Resident House Surgeon to St. Thomas's Hospital.

HOWARTH, W. G., M.A., M.B., B.C.Cantab., M.R.C.S., L.R.C.P., Resident House Surgeon to St. Thomas's Hospital.

HUGHES, PERCY T., M.B., C.M.Edin., D.P.H., Medical Superintendent to the Worcester County Asylum, Barnsley Hall, Bromsgrove.

LEEDHAM-GREEN, CHARLES, M.B.Birm., F.R.C.S.Eng., Honorary Surgeon to the Queen's Hospital, Birmingham.

MACDONALD, S. G., B.A., M.B., B.C.Cantab., M.R.C.S., L.R.C.P., House Surgeon to Out-Patients, St. Thomas's Hospital.

MACLEAN, I. C., M.R.C.S., L.R.C.P., Children's Surgical, to St. Thomas's Hospital.

MACLEAN, I. C., M.R.C.S., L.R.C.P., Electrical Department (X-Ray Department), to St. Thomas's Hospital.

NORBURY, L. E. C., M.B., B.S.Lond., M.R.C.S., L.R.C.P., Senior Casualty Officer to St. Thomas's Hospital.

PAGE, C. M., M.B., B.S.Lond., M.R.C.S., L.R.C.P., House Surgeon to Out-Patients to St. Thomas's Hospital.

PHILPOT, H. A., B.A.Oxon., M.R.C.S., L.R.C.P., House Physician to Out-patients to St. Thomas's Hospital.

SANKEY, W. O., M.R.C.S., L.R.C.P., House Physician to Out-patients to St. Thomas's Hospital.

SINGTON, H. S., M.R.C.S., L.R.C.P., Resident House Physician to St. Thomas's Hospital.

SQUIRES, H. C., M.A., M.B., B.Ch. Oxon., M.R.C.S., L.R.C.P., Resident House Physician to St. Thomas's Hospital.

STEEL, R., L.R.C.P., and S.Edin., District Medical Officer of the Auckland Union.

TREVES, F. B., B.A.Cantab., M.R.C.S., L.R.C.P., Special Department (Throat), to St. Thomas's Hospital.

WALLACE, J., B.A.Oxon., M.R.C.S., L.R.C.P., Special Department (Skin), to St. Thomas's Hospital.

WARD, W. C. A., M.R.C.S., L.R.C.P., Junior Ophthalmic House Surgeon to St. Thomas's Hospital.

WEBB, G. L., B.A., B.C.Cantab., M.R.C.S., L.R.C.P., Special Department (Skin), to St. Thomas's Hospital.

WHITEHOUSE, H. B., M.B., B.S.Lond., M.R.C.S., L.R.C.P., House Surgeon to Out-patients to St. Thomas's Hospital.

WILSON, A. G., M.B., F.R.C.S.Eng., Certifying Factory Surgeon for the West Sheffield District, co. York.

Births.

ARMSON.—On August 18th, at The Moat, Yoxall, Burton-on-Trent, the wife of Frank G. Armson, M.R.C.S., L.R.C.P., of a son.

BLOMFIELD.—On August 27th, at 211, Queen's Road, Peckham, the wife of Alfred Blomfield, M.R.C.S., L.R.C.P., of a daughter.

BOWER.—On August 28th, at Viewfield, Stretton, near Warrington, the wife of H. E. Bower, M.D., of a daughter.

BUTTERWORTH.—On August 29th, at 6, The Crescent, Wisbech, Gertrude Helen, the wife of Rupert Butterworth, B.A., M.B., B.C., Cantab., of a daughter.

PEDLEY.—On August 24th, at Wave Crest, Whitstable, the wife of S. E. Pedley, M.R.C.S., L.R.C.P., L.D.S., of Camberwell, and Regent House, Oxford Circus, London, of a son.

ROBERTSON.—On August 30th, at Althorpe, nr. Doncaster, the wife of J. F. Robertson, M.R.C.S., of a son.

Marriages.

KILROY—MACLAREN.—On September 1st, at St. Michael's Church, Camberley, Willie Dickson, son of the late Lieut.-Colonel Philip Le Feuvre Kilroy, R.A.M.C., to Edith Mary, daughter of the late Francis Blayney Maclaren, M.I.C.E., Suptg. Engr. Indian Public Works Department.

Deaths.

WHITE.—On August 26th, at Victoria Hospital, Folkestone, Richard Dormer White, M.A., M.D., Univ. Dublin, Dep. Insp.-Gen. of Hospitals and Fleets Royal Navy, aged 61.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIII. WEDNESDAY, SEPTEMBER 12, 1906. No. 11.

NOTES AND COMMENTS.

Rocks ahead in Practice.

There are many rocks ahead in the career that awaits the student who has crossed the bar of medical qualification. To paint the canvas as if it were a paradise free from care and trouble would be to produce a false picture. Sooth to say, the general practitioner who has to live by his profession will find that the financial question is always with him. In his earlier days it often becomes a hard matter to struggle on into the smoother waters of competency. Rarely is it given to him to make what business men would regard as a moderate fortune. Yet it can hardly be denied that medicine is one of the most learned and necessary of all the professions. Why, then, should it be cursed with the dead-weight of ever-narrowing income? The answer is complex. First of all, medical men have not learnt to protect their interests collectively, especially by adequate Parliamentary representation. Then there is the want of regulation as regards hospital patients, whereby many persons who can afford to pay fees are treated gratuitously. Again, there is the flood of unqualified practice and arrant quackery which swamps the efforts of the legitimate practitioner with ever-increasing volume. The student will do well to keep these facts before him, for one day they will profoundly affect his professional life.

The Quack Question.

For many years the MEDICAL PRESS AND CIRCULAR has been the bitter foe of quacks and quackery, and unqualified practice that stalks with brazen impudence through the highways and the byways of the whole kingdom. No cottage is too poor, no palace too rich to be safe from invasion by the charlatan who floods the country with pamphlets and the newspapers with advertisements, in which he claims to cure cancer, blindness, locomotor ataxy, epilepsy, chronic kidney and liver diseases, and, in short, every malady known to medical science, whether curable or incurable. Meanwhile the Legislature, which has decreed stringent laws for the education, the qualification, and the control of medical men, folds its hands and permits this wholesale illegitimate practice of medicine by unqualified persons. As a rule the police are equally supine. Of late, however, it is gratifying to note that they have prosecuted and sent to hard labour several notorious persons. Their ground of action has been clear and simple. They have brought a charge of obtaining money under false pretences, and have had no difficulty in proving their case up to the hilt. Should the police of London, Dublin, and other great cities wake up to a sense of their responsibilities, they would find their hands full for some time to come. The benefit of some such concerted action would be of incalculable value, not less to the community than to the medical profession.

How the Charlatan Robs and Slays.

For the charlatan is as multifarious as he is extortionate and callous. The average bonesetter is a perfect specimen of the class. Without a vestige of anatomical or surgical knowledge, he professes to cure all kinds of bodily deformities and injuries, the knowledge of which can only be acquired medically by a lifetime of devotion and careful training and study. Yet some bonesetters, mere ignorant colliers and the like, are permitted to conduct large practices. Needless to say, every penny they take in fees is deducted from the legitimate income of properly qualified medical men, to say nothing of the untold suffering and misery that is inflicted upon their misguided victims. A similar track of evils marks the disastrous path of other charlatans. Their list is legion: skin and nerve specialists, electricians, dermo-featural specialists, curers of deafness, blindness, paralysis, kidney diseases, and a host in other fields of irregular practice. Now, if the police chose to prosecute, there can be little doubt that even under the present defective Medical Acts the career of many of these quacks could be cut short once and for all. Where, then, are the police, and why is the British public defrauded in this bare-faced fashion? When the police prosecute they almost invariably get a conviction, yet to-day there are many worthless persons preying on the misfortunes of the public.

Police and Parliament.

The fact appears to be that no comprehensive system of police administration exists so far as prosecution of public frauds is concerned. Parliament is content to enter laws upon the Statute Book and leave their administration to fate. In the case of the medical profession, care has been taken to secure the proper persons in public posts where a qualified medical man is required. The weak point is that equal care has not been taken to exclude the unqualified medical pretender. Such is the loose wording of the Medical Acts that the quack cannot be successfully prosecuted unless he assume a title actually named in the Acts. The logical attitude of the law would be to declare illegal all actions appertaining to medical practice if performed by persons not possessing a duly recognised qualification. Precisely the same line of argument applies to police and to legislature as regards patent medicines. The false pretences of the nostrum vendor are no less obvious than those of the quack: they are just as disastrous to the community. Last, but not least, they depend for their existence upon the complacent indulgence of the newspapers which insert the advertisements of quacks and quackery.

The Lay Press and Quackery.

Newspaper proprietors generally—there is no object in mincing matters—are answerable for this enormous mass of quackery that is preying upon the community. It is saddening to reflect that a body of men, professing and inheriting the noble traditions of the British Press, can foster the existence of so dishonourable a traffic simply because of the income they derive therefrom. As a mere matter of deduction, if the police can send to hard labour a quack, they are entitled to prosecute the newspapers that have inserted his obviously fraudulent advertisements. Fancy the owners of the *Times*, or the *Standard*, or any other of the great daily newspapers—for none is free of the taint—being solemnly prosecuted for conspiracy to defraud by advertising Smith's cancer cure, or Brown's sovereign remedy for epilepsy, or Jones's specific for Bright's disease. All such medicines can be proved worthless by simple chemical analysis. Certain religious journals are notorious for the number and the reckless variety admitted to their columns. In a word, it is clear that it is to the monetary interest of the newspapers to traffic in patent medicines and in quackery. If the newspaper press were to unite with the police in the suppression of swindling quack advertisements this nefarious traffic would wither and fade within a week like grass cast into the oven. The newspapers, however, as a rule subordinate the welfare of the community to their own sordid interests.

"Truth" and Quackery.

Even those journals that set up the highest ideals seem unable to purge themselves from the taint. Take, for example, *Truth*, which is commonly looked upon as a great bulwark of society, so far as concerns exposure of shams and frauds, and which alone amongst lay journals has continuously waged war against fraudulent quacks. Yet there are spots even on this sun. Elsewhere in our present issue we print a letter from a correspondent drawing attention to a whole string of medical advertisements appearing in a single issue of *Truth*. We confess we had not previously scrutinised the columns of our contemporary for that class of announcement feeling sure they could not be found there; and we were astonished by an outburst of indignation when some weeks ago we mildly ridiculed the advertisement of the "double-chin cure," which had casually caught our eye. The value of the censorship of *Truth* over quacks and quackery, and its denunciations of the whole of the lay press for their laxity would, to put it mildly, be vastly strengthened were a closer criticism exercised over the advertisements admitted to its own columns. If *Truth* desires to co-operate with effect in the movement to obtain a Royal Commission, its position will evidently need some alteration. We confess we do not at present clearly understand it.

The "Medical Press and Circular" and Quackery.

Amongst the medical journals the MEDICAL PRESS AND CIRCULAR can claim to be the only one that has consistently followed up this subject. In season and out of season we have insisted upon the damage inflicted upon the community by the huge abuses of charlatanism. The task is a thankless one so far as the public is concerned, but we are glad to believe that our efforts are appreciated by the medical profession. A few weeks since we urged the desirability of obtaining a Royal Commission to inquire into the whole subject of quacks and quackery. That suggestion we purpose in future to make one of the chief planks in our platform. With that end in view we should be happy to open a fund for the suppression of quackery and the advocacy of a Royal Commission. Some valuable work has been done by way of repressing the evil by the Medical Defence Associations, especially by the oldest of them, the Medical Defence Union. We should earnestly advise all members of the medical profession to regard it as a matter of expediency to join one of these societies directly he secures his qualification to practise.

The Defence Unions.

For the day of trial may come to the best of us, and then it is well to have at one's back the machinery of a strong and experienced Defence Union. There is no very apparent reason why medical students should not be admitted to those societies: perhaps the point may be considered by their councils, which have shown in many directions that they are guided by a most progressive and energetic policy. Possibly they may contain the germ of future indirect protection of our profession by extending their present sphere of activity in the prosecution of quacks. That function should, in the ordinary course of things, devolve upon the General Medical Council, but that body partakes of the general topsy-turveydom of medical legislation, and has neither the will nor the power to suppress illegal medical practice. Another body that the student will do well to regard with respect from his earliest entrance to the profession is the Medical Sickness, Accident, and Insurance Society. It was founded by medical men for the benefit of the profession, and has become a splendid and assured success. It is possible that in this case also the suggestion to include medical students amongst its members might be favourably regarded.

Advice to the Student.

There are certain things that the student of medicine will do well to keep in his mind from the outset of his professional career. In after life, at any rate, he will find that the keen delights of scientific research and of philosophical method have to become subservient to the necessity of making a livelihood. So far as the latter point is concerned, he will find himself seriously handicapped in various ways. One thing he can do while at hospital is to satisfy himself of the reality of the abuse of medical charities by persons who can afford to pay outside practitioners. Let him bear in mind that every time he ministers to such a person he is depriving some practitioner outside the walls of the hospital of a legitimate fee even if it be no more than the shilling or eighteenpence to which want of organisation and adequate defence has reduced the general practitioner. It may not be possible for the student to decline to treat a well-to-do patient. Such a step is likely to bring him into disfavour with the hospital authorities, who do not care to discourage this increase of patients. With the Managing Committee and the Secretary, large numbers indicate popularity, and score with the public. They care not one jot for the outside medical man, who has to look after his own interests—if he can.

Further Advice.

These may sound hard words, but their truth has to be learnt sooner or later by an overwhelming proportion of the rank and file of the medical profession. Happily, there are signs on the horizon that the profession intends seriously to grapple with this unfair hospital competition.

The student will also do well to keep an eye on the evils wrought by quacks and quack medicines. The money obtained by that means from the community is to a great extent diverted from the income of medical men. There is little comfort to the struggling practitioner to remind him that in the long run the use of patent medicines brings many persons back to his consulting rooms. The student had better grasp this fact early in his career, namely, that in most cases it is possible to secure a moderate competency in practice, rarely more, and that in most instances the consciousness of a life devoted to a high and honourable calling will be his chief reward. That reflection has been the mainstay of many a man of culture and noble purpose, condemned to live through days of prolonged financial narrowness. There is no need, however, as we have more than hinted, why the medical man of the future should not unite noble aims with the possession of adequate income, provided he can organise sufficiently to insist upon the recognition of his just professional rights.

M. Tanqueray again.

A further letter from Tanqueray, of Paris, to whose solicitude to provide free portraits for the medical profession we have already referred, has been received by the member of our staff who foolishly sent a photograph for reproduction in accordance with Tanqueray's original and enticing offer. As our previous note on this subject proved interesting to some of our readers, the contents of the latest, and we believe the last, communication from Tanqueray, may also be of interest. He commences by calling attention to the beauty of the portrait which awaits its owner in his studio, and explains that it requires careful package. He then expresses his willingness to send it "free of all expense" for the sum of eight shillings, and, in addition, to present the recipient with a "handsome detective camera" with developing and printing outfit complete. It may be remembered that the original offer was to send the portrait for ten shillings, which sum would cover package and carriage. Now, for eight shillings, one receives not only the portrait, but also the photographic equipment "free of all expense." Whether the latter cryptic phrase means "carriage paid" we leave our readers to imagine. In view of Dr. Falls' experience, as recorded in the MEDICAL PRESS AND CIRCULAR for August 29, we have no doubt on the subject. Tanqueray ends his last letter by saying that if he does not hear within thirty days, he will assume that "neither your portrait nor your photograph are of any interest to you"—in other words, a plain threat that if he is not paid he will not return the original photograph. We further note that, whereas on the letter addressed to and retained by the customer, the offer is to send the portrait "free of all expense," on the order-form, *which is to be returned to Paris* with the money, the statement is made that the eight shillings prepays all charges of boxing, packing and carriage. A very ingenious trick!

SIR FRANCIS LAKING, Bart., Physician in Ordinary to His Majesty the King, was conveyed in a special train from Abergeldie to Aberdeen yesterday, and is now in a private nursing home. He was taken ill at Abergeldie, and is not progressing favourably.

PERSONAL.

THE Huxley Lecture will be delivered at Charing Cross Hospital Medical School by Professor Ivan Petrovitsch Pawlow, Professor of Physiology, University of St. Petersburg, on Monday, October 1st, 1906, at 4 p.m.

THE first report of the expedition to the Amazon, organised by the Liverpool School of Tropical Medicine has been issued by Dr. H. Wolferstan Thomas.

PROF. CLIFFORD ALLBUTT, F.R.S., will deliver an address at the opening of the Winter Session at Guy's Hospital, on October 1st.

MR. PRIDGIN TEALE, F.R.S., will open the Session at King's College Hospital with an introductory lecture on October 2nd, whilst Prof. R. Godlee will re-open University College Hospital.

ON October 1st the Dean of St. Mary's Hospital, Dr. W. H. Alcock, will deliver the inaugural address. On the same date Dr. H. Campbell Thomson will perform the same function at Middlesex Hospital, and Dr. de Havilland Hall, at Westminster.

THE Winter Session at the London Hospital will be opened by a dinner under the presidency of Mr. John Holroyde, of Rochester.

PROF. BYERS will open the Session at the London School of Medicine for Women on October 1st, and on the same date Colonel Kenneth Macleod, I.M.S., will deliver the inaugural address at the London School of Tropical Medicine.

PRINCESS HENRY OF BATTENBERG last week paid a visit to the Royal National Hospital for Consumption at Ventnor, after opening the fête and bazaar, for the purpose of completing the fund of £1,000 for the endowment of a bed in memory of Dr. Sinclair Coghill, the late senior physician.

A MARIENBAD correspondent writes:—"The King's departure for England signalizes the break-up of a season which, apart from the painful sensation caused by the death of Lady Campbell-Bannerman, has been the most enjoyable ever experienced here. There can be little doubt that, when the King arrives home, it will be agreed that seldom has he appeared in better health and spirits as the result of a Continental holiday. I know that Dr. Ott, under whose care the King has been taking the cure, is very well satisfied with the progress made by his patient. Several sittings have been given by His Majesty to Herr Gurschner, who is engaged on a model of the King's features for the monument to be erected in the town. A further item of Marienbad news is that some of the scandal-mongers who had been busy with the name of a young and beautiful Society dame, have received a sharp rebuff from an unexpected quarter."

I LEARN that Sir Frederick Treves, who has been in attendance on Queen Alexandra throughout her absence from England, is returning specially from Copenhagen in order to arrive in London in time to have an interview with the King before His Majesty's departure for Doncaster. The King is naturally very anxious to learn from Sir Frederick's own lips the real state of Her Majesty's health, and to discuss whether it would be better that her journey from Copenhagen to Scotland, later in the month, should be made entirely by sea, or broken by a rest in London,

EDUCATIONAL SUMMARY FOR 1906-7.

INTRODUCTORY REMARKS.

THERE are two classes of people for whom a Students' number is primarily intended, namely, those who may be thinking of taking up Medicine as a career, and those who have already decided to do so and who wish for guidance as to the school they should choose, and the line of professional activity they should adopt in the future. To the former class we unhesitatingly say, "Take full time and make every possible inquiry before arriving at your decision, remembering that if a man hesitates about choosing Medicine for a career, the strong probabilities are that he is not suited by nature for its pursuit." Medicine as a means of livelihood demands so much self-sacrifice and so much really hard work that unless a man is attuned by nature to the peculiar circumstances attending its practice it is far better for him, and certainly far better for the public, that he should find some more congenial sphere for his talents. The world is full of minor tragedies, and of these misapplied lives are by no means the least; there are many medical men in practice to-day whose minds fluctuate so much between regret for the past and anxiety for the future that they are unable to do justice to the daily round of duty. Such men might have made admirable soldiers, bankers, or colonists, but obviously they do not make the best doctors, even if they make good doctors at all. Therefore it cannot be too strongly impressed on those whose thoughts turn towards Medicine, that they should examine themselves as to whether they are worthy of the aim. But Medicine with all its trials and responsibilities has pleasures and privileges all its own, and there are not a few who love their work and their patients and their lives with a fondness that could be evoked by no other calling. Such men are not necessarily intellectual giants nor the most eminent practisers of their art, but they have that within them which vibrates sympathetically with the note struck by their surroundings; they give and receive pleasure with equal facility.

Happiness in the practice of Medicine, indeed, may be said to be a question of aim and a question of disposition. It may be taken for granted that pre-eminence in the State and great wealth will never come to the doctor, however intellectual, industrious, and successful he may be; if a man be possessed of such qualities, and wishes to make the best of them, he had better not adopt Medicine for his profession. The law, the church, the army and navy will all bring him distinction, a title, and the two former, at least, wealth. He will find nothing of the sort in the medical profession unless he become a Court doctor, and "the fashion," when he may be made a baronet and earn a fair income for a few years. The type of man who aims at these distinctions, however, had better choose some other career, for not only is the conventional consideration accorded to the leaders of the profession of Medicine far below that accorded to a judge, a general, or a wealthy brewer, but their work is far harder. If, on the other hand, a man endowed with good talents and resolution wishes to use these not solely for his own advancement and comfort, but would like them to be of service to his fellows, he will probably find in the practice of Medicine a wider field for their application and a more tangible amount of good to be done than in any other path in life. Success in Medicine, in fact, is not capable of being gauged accurately by the bank-ledger and precedence at Court, because the work of the doctor consists, or should consist, in giving as much as in taking, and the doctor's pleasure is, or should be, as great in seeing his patients in good health as in being able to provide the amenities of life for his own family. Medical practice must always be regarded as a form of altruism, out of which if the doctor saves sufficient to keep himself going, he is abundantly content. As men in other walks of life regard their business or calling as a means of livelihood, and only consent to give away of their surplus, they are generally unable to see things from the doctor's standpoint, and medical men are consequently written down as "unbusinesslike." And this is perfectly true, for the aims of "business" are purely selfish, whilst those of medicine are as much unselfish as selfish. The aspirant after medical skill and knowledge cannot be given too clearly to understand that success in Medicine is different to success in other professions, and that the medical man who gains worldly applause but is not rewarded by the happiness that comes from otherworldliness is a failure, whilst an obscure practitioner who mixes his pills with kindness and receives gratitude with his humble fees is a success. The difference between the practice of Medicine and the pursuit of any other calling, then, is a difference of ideal, and unless a man is willing, nay, eager, to subordinate his own advantage to the requirements of the medical ideal, he will never be content with the profession as a sphere for advancement. If, however, he enters its portals in a spirit of devotion and self-subordination, he will find greater opportunities for the exhibition of these virtues than is generally appreciated.

CHOICE OF A SCHOOL.

The decision to study Medicine once made, no reasonable person can grumble at the variety of schools provided in the British Isles. Some twenty centres of medical instruction at present exist, and most of them embrace so many individual colleges and hospitals that the would-be student who tries impartially to balance the advantages presented by them all is likely to find himself in an agony of indecision. Some of the centres are complete and self-contained. A man has only to enter, pay his fees, pass his exams, and emerge on the Medical Register with the automatic precision of an American sausage-manufactory. Others cater only for the preliminary education of the students, and others again only for those who would complete their course. Some give a degree, others a qualification, and still others refer those who study with them to a diploma-granting corporation. Some have large hospitals and few students; others small hospitals and many students; some rely on the reputation their teachers have gained as practitioners; others on the quality of instruction provided by more obscure individuals; some are possessed of influence and prestige; others are struggling to make a name. The only quality they have in common seems to be a desire for students, so that a man is likely to find himself welcome wherever he goes. To attempt specific guidance in the maze of these competing attractions is a thankless task. Full particulars of the advantages provided by all will be found in the pages of this number.

CHOICE OF QUALIFICATIONS.

It may be safely asserted that a man who possesses a university degree has a distinct pull over a man who possesses a diploma only. The only exception is when purely surgical practice is aimed at, and the aspirant is armed with the fellowship of one of the Colleges of Surgeons. Even then the addition of M.B. to his qualifications will, *cæteris paribus*, be found helpful. Many men enter at a medical school with no clear idea of what they are in for, and too late they realise that they have trodden the path which leads only to a diploma, and which will land them in a disadvantageous position as compared with their degree-possessing brethren. The best universities, generally speaking, provide the stiffest examinations, and their degrees naturally confer the greatest *éclat* on those who hold them, but in these days of competition it is not difficult for a man who wishes to be less severely tested to find universities who give their M.B. for work of no higher standard than is rewarded with a diploma only in other centres.

COURSE OF STUDY.

Five years' study is now obligatory in all schools thanks to the efforts of the General Medical Council, but the man who completes all that is required of him in that time and finds himself fully qualified at the end is a *rara avis*. Seven years are found to be about the average for men of all capacities, and parents of limited means and guardians who wish to see their wards self-supporting would do well to pay attention to this fact. As legal qualification does not necessarily connote more than the potentiality to earn an income, expense cannot be considered at an end when the diploma is framed and displayed to admiring friends.

CHOICE OF A CAREER.

The future of a medical man once he is qualified will depend on his tastes, means, influence, and ability. The majority of men naturally go into general practice, the locality in which they settle and the class of practice they obtain being determined by personal connection or financial resources. A man of small means will settle in the neighbourhood of the poor who pay very small fees, whilst a man who is well off will take a good house in a fashionable quarter and cater for the rich and well-to-do who pay proportionately more. For those who are averse from private practice there are the services, the Army, Navy, West African, Colonial, and Indian Medical, in all of which pay, prospects and status have improved of late years; the various county asylums, each of which maintains a small resident medical staff; the poor-law infirmaries and fever hospitals, in both of which pay is low and prospects poor; the health departments of the municipalities and counties, in which a man who is contented with a few hundreds a year may, after some years of waiting, possibly acquire them; and various minor services, such as the prisons, which offer but little inducement to men of enterprise and energy. Consulting and special practice will come to a few men if they are successful in getting on the staff of a large hospital and have a sufficient income to support a more or less pretentious establishment for ten, fifteen, or twenty years.

SUMMARY.

Generally it may be said, then, that Medicine offers to its followers a career of great usefulness, and for those who have good health and devotion of character a life that will afford many peculiar pleasures. There is no opening in it for the idle, wanton and dissolute, and as everything depends on personal exertion the delicate will find their health an insuperable handicap. For men of good ability and merit, a competency is attainable, and there is always room at the top.

THE ENGLISH UNIVERSITIES.

THE English Universities are eight in number, *viz.*, Oxford, Cambridge, London, the Victoria, Durham, Liverpool, Leeds, and 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, since their degrees confer upon their holders a status not accorded by the public to the degrees of more modern educational institutions. To those less favoured by fortune, but blessed with energy and a fair share of intelligence, the London University offers ample scope, and its degrees are recognised as the outward and visible sign of high professional attainments. A capable and industrious student, however, may equally well lay the foundations of success in one of the newer provincial universities.

OXFORD.

There are two degrees in medicine, B.M. and D.M., and two degrees in surgery, B.Ch. and M.Ch. The B.M. and B.Ch. degrees are granted to those members of the University who have passed the second (B.M.) examination. Graduates in Arts, B.A., are alone eligible for these degrees. In order to obtain the degrees of B.M. and B.Ch., the following examinations must be passed :—1. Preliminary : Subjects :—Physics, chemistry, zoology, 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; Materia medica with pharmacy. (*b*) Second examination : Subjects :—Medicine, surgery, midwifery, pathology, forensic medicine with hygiene. The approximate dates of the examinations are as follow : —Preliminaries:—Physics, chemistry, and botany, December and June; Zoology, March and June; Professional (First and Second B.M.), June and December.

The degree of D.M. is granted to Bachelors of Medicine of the University who have entered on their thirty-ninth term on their presenting a dissertation approved of 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.

The First examination for the degrees of B.M. 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 offered and passed together.

In the Second examination candidates are allowed to present themselves in pathology, and also in forensic medicine at separate examinations at any time after the First examination has been passed; but no candidate is permitted to enter for the examinations in medicine, surgery, and midwifery until he has attained the twenty-fourth term from his matriculation—*i.e.*, six years.

Diploma in Public Health.—The examination for the Diploma is held about the end of November in each year, and is open to any registered medical practitioner, whether he be a graduate of the University of Oxford or not. It is conducted according to the statutes and regulations of the University, and these have been framed so as to be consonant with the Resolutions and rules adopted by the General Medical Council for Diplomas in Public Health.

The examination consists of two parts. In the first of these candidates are required to exhibit a knowledge of chemistry and physics in the relations of these sciences to Public Health. In the second part of the Examination the candidate is examined in the subjects of general hygiene and of pathology in its bearings on Public Health. In all the subjects the Examination is partly practical. Candidates may offer themselves for the two parts of the examination on the same occasion or on different occasions; but their admission to the second part is contingent on their having already satisfied the examiners in the first part.

Candidates who desire to prepare for the examination within the University will be afforded facilities for doing so in the laboratories of the scientific departments concerned with the subjects of examination; and arrangements can also be made for candidates to acquire a practical knowledge of the duties of Public Health administration under the supervision of the Medical Officer of Health for the City of Oxford. Information on these points may be obtained by application to the Regius Professor of Medicine, University Museum, Oxford.

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 (1) chemistry and physics, and (2) biology; the second in human anatomy and physiology; and the third in (1) pharmacology and general pathology, (2) in surgery, midwifery, and medicine. The first and the third examinations are 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, including the presentation of an original thesis, 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 submits 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 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.

There is also a special examination in Tropical Medicine and Hygiene, held annually in August. It is open to qualified practitioners under certain conditions as to previous study and experience. Successful candidates receive a University Diploma.

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 Medical Faculty grants the degrees of Bachelor of Medicine and Surgery, Doctor of Medicine and Master in Surgery. Under the new regulations the students are divided into "Internal" and "External" An internal student is one who has matriculated at the University and is studying in a school approved by that body, or under the teachers of the University. An external student is one who has adopted an alternative course of study. The regulations differ somewhat in their application to the two groups of students. We only propose to deal with them as they affect *internal* students, since the special information required by the others had best be obtained direct from the Registrar. Under no circumstances will a student be admitted to the final examination for a degree until at least three years have elapsed since matriculation or other examination entitling to registration as a medical student.*

The Matriculation Examination takes place thrice yearly—in January, June (or July), and September. Application for admission to it must be made on a special form about six weeks beforehand, and the candidate must have completed his 16th year at the date of the examination. Candidates must show a competent knowledge of five subjects, among which *must* be English and elementary mathematics. The other three (one of them a language) may be selected from the following:—Latin, Greek, French, German, Arabic,* Sanscrit,* Spanish,* Portuguese,* Italian,* Hebrew,* Ancient History, Modern History, Logic, Physical and General Geography, Geometrical and Mechanical Drawing, Mathematics (more advanced than in the compulsory examination), Elementary Mechanics, Elementary Chemistry, Elementary Biology (Botany), Elementary Biology (Zoology),* Elementary Physics, Heat, Light, and Sound, Electricity, and Magnetism. Candidates who desire to be examined in the subjects against which an asterisk is affixed must give at least two months' notice.

The Preliminary Scientific Examination will take place twice in each year, in January and July. It will consist of papers on inorganic chemistry, biology, and physics, and there will be a practical examination in each subject. Examiners will also be at liberty to test candidates *viva voce*. A student may present himself for examination in each of the three subjects, separately or in all at the same time. Part I. of this examination includes papers in inorganic chemistry, physics, and biology, with practical examinations; Part II. is an examination in organic chemistry. Six months must elapse after passing Part I.

The Intermediate Examination in Medicine will take place twice a year, January and July. Candidates must have passed the Preliminary Scientific Examination at least two years previously. The subjects of examination are Anatomy, Physiology and Histology, and Pharmacology, including Materia Medica. Candidates who have failed in one subject only at this examination may offer themselves for re-examination in that subject, if permitted to do so by the

* May obtain registration as Internal or External students on presentation of documentary evidence as to their condition and a payment of £2; Graduates of such British, Colonial, and foreign Universities as are approved by the Senate for that purpose, and those who have passed all the examinations required for a degree in those Universities also women who have obtained Tripos certificates granted by the University of Cambridge, and women who have obtained certificates showing that, under the conditions prescribed by the Delegacy for Local Examinations at Oxford, they have passed the Second Public Examination of that University or have obtained honours in the Oxford University Examination for Women in Modern Languages, and students who hold the Scotch School Leaving Certificate, having passed on one and the same occasion, in the Higher or Honours Grade in all the subjects required by the regulations for the Matriculation Examination.

examiners. Three scholarships, one of the value of £40 in Anatomy, another of the same amount in Physiology, and one of £30 in Pharmacology may be awarded by the examiners to any candidate who has passed the whole of the examination at one time.

Provincial Examinations for Matriculation.—These examinations are appointed by the Senate from time to time upon the application of any city, institution, or college desiring to be named as a local centre for one or more examinations in London under the supervision of sub-examiners also appointed by the Senate. Candidates wishing to be examined at any centre must give notice upon their forms of entry to the Principal of the University. Besides the University fee a fee usually varying from £1 to £3 is charged by the local authorities and must be paid *at the local centre* before the commencement of the examination.

The Final M.B., B.S., Examination will take place twice a year, in October and May. No candidate will be admitted to this examination unless he has completed the course of study prescribed in the schedule or in less than two academic years from the date of passing the Intermediate Examination in anatomy and physiology.

The subjects of the examination are Medicine (including Therapeutics and Mental Diseases), Pathology, Forensic Medicine and Hygiene, Surgery, and Midwifery and Diseases of Women. The subjects may be divided into two groups, one of which shall comprise Medicine, Pathology, Forensic Medicine and Hygiene; and the other Surgery, Midwifery and Diseases of Women. Either group may be taken first at the option of the candidate, or the groups may be taken together.

Only candidates who show a competent knowledge of all the subjects comprising a group will be passed. The examiners will be empowered to recommend the award of a University Medal to the candidate who has most distinguished himself in the whole examination.

Doctor of Medicine.—The examination for the degree of Doctor of Medicine will be held twice in each year, in December and July. Every candidate must have passed the examination for the M.B., B.S., of this University. Candidates may present themselves for examination in one of the following branches: (1) Medicine, (2) Pathology, (3) Mental Diseases, (4) Midwifery and Diseases of Women, (5) State Medicine: and if they wish, may pass also in another branch at a subsequent examination. Candidates for Branches 1 to 4 who have taken honours at the M.B., B.S. examination in the subject in which they present themselves for the M.D. degree, or who, subsequently to taking the M.B., B.S., have conducted a piece of original work approved for the purpose by the University, or have had special experience approved by the University, may present themselves for the M.D. examination one year after taking their Bachelor's degree. Other candidates must show that they have taken the degree of M.B., B.S., not less than two years previously; and as regards candidates in Branches 1 to 4, that subsequently to taking that degree they have held for at least six months a resident or non-resident medical hospital appointment, or that they have been in qualified practice for not less than five years, while candidates in Branches 2 and 3 must show that they have held in the one case a pathological and in the other an asylum appointment. In each branch there will be (1) two papers on the special subject of the branch; (2) a clinical examination; (3) an essay to be written on one of two given subjects connected with the branch. In Branch 1 there will also be a paper on pathology, and in Branches 2, 3, and 4 a paper in medicine, while in Branch 2 a laboratory examination will be substituted for the Clinical Examination held in the other branches.

Candidates in Branch 5 (State Medicine) must show that they have taken the degrees M.B., B.S. not less than two years previously, and that subsequently to taking those degrees they have had (1) six months' practical instruction in an approved laboratory; (2) six months' practical instruction from a medical officer of health, of which three must not coincide with the laboratory work, and three months' practice at a hospital for infectious diseases. The interval between passing the M.B., B.S. and proceeding to the M.D. State Medicine may be reduced to one year, subject to conditions corresponding to those affecting Branches 1, 2, 3, and 4.

Master of Surgery.—The examination for the degree of Master in Surgery will take place twice in each year, commencing on the same dates as the foregoing, and the general regulations already quoted with regard to the M.D. will practically apply to it, surgery being substituted for medicine. The examination will consist of (1) two papers on surgery (one of which may be a case for commentary); (2) an essay to be written on one of two subjects which may be selected from any branch of surgery; (3) two papers on surgical pathology and surgical anatomy; (4) a clinical examination; (5) operations on the dead body; (6) a *viva voce* at the discretion of the examiners. Competent knowledge in every subject of the examination must be shown in order to pass.

For the M.S. degree and all branches of the M.D. a candidate is at liberty to forward a thesis or copies of published works embodying the result of independent research in the subject in which he presents himself for a degree and also any printed contributions to the advancement of professional knowledge published either separately or conjointly. If the examiners consider such thesis or works of sufficient merit they are empowered to exempt a candidate partly or entirely from examination in the subject to which such work refers. They also have power to award a University Medal to the candidate who at the examination in any branch passes with most distinction.

Fees.—For Matriculation, £2 for each entry. Preliminary Scientific Examination.—Part I: £5 for each entry to the whole examination, and £2 for each subject when less than the whole examination is taken at one time. Part II.: No fee for first entry, £2 for each subsequent one. Intermediate Examination.—£10 for each entry to the whole examination, and £5 for re-examination in one subject. M.B. B.S. Examination.—£10 for each entry to the whole examination, and £5 for examination or re-examination in either group. M.D. and M.S. Examinations.—£20 for each entry.

This University has established centres for preliminary and intermediate studies at University and King's Colleges, and students who purpose taking the London degree should make themselves acquainted with the details attached to external and internal students. Information on these points may be had of the Academic Registrar, University of London, South Kensington.

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. First and second year students (dating from registration) are not required to comply with the regulation regarding attendance on hospital practice. Candidates who have passed the First and Second Examinations of the University will be exempt

from the First and Second Examinations 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 or German. In case they shall not have passed in either of these subjects at the Preliminary Examinations 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 or German. In case they shall not have passed in either of these subjects at the Preliminary Examinations 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 of 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 naval or military services, or in medical or surgical practice.

Each candidate must present an essay which has been prepared entirely by himself, and which must be typewritten, 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 1905-6.

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. In the case of the M.D. (Essay) Examination, candidates must send in their essays six weeks before the date of the examination.

Attached to this University for the acquirement of medical study and hospital practice, is the Royal Infirmary, a very commodious and ornate building, with 280 beds. Pathological demonstrations are given as opportunity offers. A new wing has been added to the College of Medicine to accommodate the departments of physiology and bacteriology. It also contains students' union rooms and gymnasium.

The New Royal Victoria Infirmary, containing 450 beds, has recently been opened by H.M. the King. In the new infirmary adequate accommodation will be provided for the study of the various special subjects, in addition to the ordinary clinical work. 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, and at the Northumberland County Lunatic Asylum.

There are various appointments open to the students, some carrying with them an honorarium, whilst the scholarships available are numerous and of considerable value.

Fees.—(*a*) A composition ticket for lectures at the college may be obtained—1. By payment of 72 guineas on entrance. 2. By payment of 46 guineas at the commencement of the first sessional year and 36 guineas at the commencement of the second sessional year. 3. By three annual instalments of 36, 31, 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, five guineas; for six months, eight guineas; one year, twelve guineas composition fee in one payment, twenty-five guineas; or by three instalments at the commencement of the sessional year, *viz.*, first year, 12 guineas: second year, ten guineas; third year, six guineas; or by two instalments, *viz.*, first year, fourteen guineas; second year, twelve guineas. In addition, two guineas yearly up to three years must be paid to the Committee of the Royal Infirmary.

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.

MANCHESTER UNIVERSITY.

Candidates for degrees in medicine and surgery must attend classes in the University during at least two years.

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 Matriculation 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 Matriculation Examination are—1, Latin; 2, mathematics; 3, mechanics; 4, English and history; 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 Joint Matriculation Board. Notice of intention to present either Italian or Spanish must be given to the Secretary, Joint Matriculation Board, Manchester, 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, and must have attended courses of both lectures and laboratory work.

The final 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.—Matriculation examination, £2. 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 £5 on the conferring of the degree of Ch.M.

The Matriculation Examination is held in July 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.

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. 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.

The appointments open to students are numerous and of considerable monetary value, and there are probably more here than are available at any other medical centre. The principal are:—Nine Entrance scholarships, the Leech fellowship of £100; Entrance scholarships in medicine, £100 (towards College and Infirmary fees); Manchester Grammar School scholarships, two or three of not less than £15 or more than £30 per annum for three years; Turner scholarship of £20 to students who have completed a course of medical study in the University; Platt physiological scholarships, two of the value of £50 each; Platt zoological and botanical scholarship, £50; Professor Tom Jones' memorial surgical scholarship of £100, awarded triennially; two Dauntsey medical entrance scholarships, value £35; John Henry Agnew scholarship in diseases of children, value £30, awarded annually; Graduate scholarship in medicine, £25 to £50, awarded annually; and many others.

Fees.—Composition fee, 83 guineas, in three instalments of 23, 30 and 30 guineas. Hospital practice: Composition fee, £42, or two instalments of £22 each.

Dental Fees.—Composition fee, £60, payable in two sums of £30 each. Hospital practice, £21.

BIRMINGHAM UNIVERSITY.

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. As a rule, 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, but the Senate has power of recognising attendance at another University as part of the attendance qualifying for these degrees.

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*) Responsions 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 examination (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.—At the end of one year from the date of having passed the Final M.B., Ch.B. Examination, the candidate will be eligible to present himself for the higher Degrees of either Doctor of Medicine or Master of Surgery or both, the regulations for which may be had upon application to the Dean. The University also grants a Degree and a Diploma in Public Health, and provides adequate instructions for the same.

Dental Department.—The University grants the Degrees of Bachelor and Master of Dental Surgery (B.D.S. and M.D.S.), and a Diploma in Dental Surgery (L.D.S.). The whole of the instruction for which may be taken out in the University, with which is associated the Birmingham Dental Hospital.

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. 8,000 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 Gilbert Barling, Dean, Medical Faculty.

UNIVERSITY OF LIVERPOOL.

The Degrees in the Faculty of Medicine are Bachelor of Medicine and Bachelor of Surgery (M.B. and Ch.B.), Doctor of Medicine (M.D.), and Master of Surgery (Ch.M.). The course of study for the Degrees of Bachelor of Medicine and Bachelor of Surgery is of five years' duration, and of this period two years must be spent at the University, the remaining three years can be taken in any medical school approved by the University.

The University provides a complete curriculum for these Degrees, and possesses modern and well-equipped laboratories and class-rooms for the teaching of all the subjects.

For the Degree of M.D., a thesis is required which may be presented not earlier than one year after graduation, as M.B., Ch.B.

The degree of Ch.M. is given after a period of at least one year of further study after graduation as M.B., Ch.B., on the results of an examination.

Diplomas.—Diplomas have been instituted in Public Health (D.P.H.), Topical Medicine (D.T.M.), and Veterinary Hygiene (D.V.H.). Special diplomas are also granted in Anatomy, Bacteriology, Bio-chemistry, and Parasitology after a course of study of three terms in the subject chosen and allied subjects.

A Diploma (L.D.S.) and Degrees (B.D.S. and M.D.S.) have recently been instituted in dental surgery. These are only conferred upon students of the University. Particulars may be obtained from the Registrar.

Students may enter for the degrees of the University of Liverpool, or may study for the degrees and qualifications of the other licensing bodies.

Hospitals.—The Clinical School of the University now consists of four general hospitals—the Royal Infirmary, the David Lewis Northern Hospital, the Royal Southern Hospital, and the Stanley Hospital; and of five special hospitals—the Eye and Ear Infirmary, the Hospital for Women, the Infirmary for Children, St. Paul's Eye and Ear Hospital, and St. George's Hospital for Skin Diseases. These hospitals contain in all a total of 1,127 beds. The organisation of these hospitals to form one teaching institution provides the medical student and the medical practitioner with an unrivalled field for clinical education and study, and all are within easy access from the university. The period of hospital practice extends over the last three years of medical study. During the first two years no student will be permitted to change his attendance from one general hospital to another except at the commencement of an academic term. It is a regulation of the school that not more than five of the six terms of these two years shall be spent at any single General Hospital. During the final year of hospital practice a student is permitted to attend the practice of all the general hospitals without restriction. The regulations demand only that his attendance shall be regular and to the satisfaction of the Hospital's Board. There are a large number of appointments to House Physicianships and surgeonships both at the general and special hospitals, which are open to qualified students of the School. These appointments (20) in most cases carry salaries varying from £60 to £100 per annum.

Fellowships and Scholarships.—Fellowships, Scholarships, and Prizes of over £800 are awarded annually. 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. A Holt Fellowship in Physiology, awarded under similar conditions, also of the value of £100 for one year. A Robert Gee Fellowship in Anatomy, awarded under similar conditions, of the value of £100 for one year. An Alexander Fellowship for Research in Pathology of the annual value of £100, renewable. A Johnston Colonial Fellowship in Pathology and Bacteriology (£100 a year, renewable). A John W. Garrett International Fellowship in Physiology and Pathology (£100 a year, renewable). An Ethel Boyce Fellowship in Gynæcological Pathology (£100 a year, renewable). A Stopford Taylor Fellowship (£100 a year, renewable) in Dermatological Pathology. A Thelwall Thomas Fellowship (£100 a year, renewable) in Surgical Pathology. 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 Liverpool 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, in the subjects of Anatomy, Physiology, and Therapeutics. 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 1907 the subject will be Clinical Medicine. The Torr Gold Medal in Anatomy, the George Holt Medal in Physiology, the Kanthack Medal in Pathology, and the Robert Gee Book Prize, of the value of £5, for Children's Diseases.

Entrance Scholarships.—Two Robert Gee Entrance Scholarships, of the annual value each of £25 for two years, 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 Benjamin Moore, M.A., D.Sc., the University, Liverpool.

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 (L.S.A.) in medicine, surgery, and midwifery.

CONJOINT EXAMINING BOARD IN ENGLAND.

Candidates for the above licences are required to complete five years of professional study at recognised medical schools and hospitals, after passing the preliminary examination, of which six months may be spent at an institution recognised by the Board for instruction in chemistry, or one year may be passed at an institution recognised by the Board for instruction in chemistry and physics, 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, fourteen clear days' notice before the day on which the examination commences being required, the candidate 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 is allowed to take this examination in three parts at different times. Rejection entails a delay of not less than three months from the date of rejection, and the candidate 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. Practical pharmacy may be passed at any time during the curriculum. 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 follow:—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 has 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 gynæcology. Candidates may take this examination in three parts separately, or they may present themselves for the whole examination at one time.

Fees for admission to the third or final examination are as follow:—For the whole examination, £21 0s. 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 gynæcology, £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.

REGULATIONS FOR COLONIAL, INDIAN, AND FOREIGN CANDIDATES, AND UNIVERSITY CANDIDATES.

Persons holding a Colonial, Indian, or a foreign qualification entitling them to practise medicine in the country of origin, and conferred after a course of study and examinations equivalent to those required by the Royal Colleges, are admissible to the second and third (final) examinations forthwith.

Members of a University in the United Kingdom are, under certain conditions, eligible for admission to the third (final) examination two years after passing at their University in the subjects included in the first and second examinations of the Board.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

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 5s. 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.—First examination, £5 5s.; second examination, £12 12s. The total fee payable on admission to the Fellowship is £31 10s., except for members, when the fee is £21. (The examination fees to the extent of £17 17s. count as part of the total fee.) Further information can be obtained on application to the Secretary of the Royal College of Surgeons, Lincoln's Inn Fields, London, W.C.

There are two examinations—primary and final. The primary examination is held quarterly on the first Wednesday, and on the Monday and Tuesday in the same week, in the months of January, April, July, and October. The final examination is held monthly.

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, Gynæcology, 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.

Section 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.—Primary examination, £5 5s.; final examination, £15 15s.; total fee, £21.

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.

This 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 Gillson scholarship in Pathology of the annual value of £90, tenable for one year, is open to Licentiates of the Society and to candidates for the diploma who obtain it within six months of election to the scholarship. An examination in the art of prescribing is held annually, in January, at which the following prizes are awarded:—A gold medal of the value of £6; a silver medal, and a prize of books to the two best candidates.

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, lecturers, 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 students than any other medical school in London. Laboratories have been specially equipped for the study of pathology, bacteriology, chemistry, biology, physics, and chemical pathology, and two additional operation theatres have just been built. A new block of buildings is in course of erection at a cost of £120,000, and will contain new casualty and out-patients' departments, eight special departments, quarters for the junior staff, a dining hall and a common-room for students, &c. Collegiate residence is permissible, subject to the ordinary rules.

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 anæsthetists 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. Chief assistants and clinical assistants are appointed in each of the special departments. In-patient dressers, in-patient clinical clerks, clerks, and dressers to the assistant physicians, and assistant surgeons, 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; at the end of first year four junior scholarships of £30, £20, £25, £15, respectively; Treasurer's prize for practical anatomy; Foster prize in practical anatomy; senior scholarship, 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 Brackenbury scholarships, of £39, in medicine and surgery; Bentley prize, for reports of 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; Matthews Duncan prize, medal and about £20; Willett medal and Walsham prize; Holden Research Scholarship in Surgery, value £105.

Fees.—By payment of an annual composition fee, a student is entitled to attend all the courses of instruction, and to hold the various clinical appointments. For students commencing their medical studies:—Entrance fee, 30 guineas; annual fee, 30 guineas, for five years, or a single payment of 165 guineas. A student on qualification at the end of the five years is not liable for any further fees, and receives a perpetual ticket. Should he fail to qualify in this time, the fee for further instruction is 10 guineas for each six months. Fees for University students:—Entrance fee, 20 guineas; 30 guineas, annually for two years, and 10 guineas for each six months if not qualified. Fees for preliminary scientific students:—20 guineas; for laboratory instruction for D.P.H., 15 guineas.

Dean, Dr. T. W. Shore, will furnish further details on application.

CHARING CROSS HOSPITAL.—The Winter Session will be opened on Monday, October 1st, by the delivery of the sixth Biennial Huxley Lecture by Professor Ivan Petrovitsch Pawlow, of St. Petersburg.

The school attached to this hospital is situated in Central London, and contains new physiological, pathological, and bacteriological laboratories, materia medica and anatomical museums, an anatomical theatre, enlarged dissecting-room, and chemical theatre. 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 eye, nose and ear, and in the orthopædic, Röntgen, and electrical departments, there are several scholarships and prizes, particulars of which can be obtained of the Dean.

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 and dressers 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, 115 guineas in one sum, by sessional payments as follows: Entrance fee, 10 guineas. In addition a sum of 15 guineas must be paid at the beginning of every Winter Session, and one of 10 guineas at the beginning of every Summer Session so long as the student remains in the school. For dental students, 55 guineas in one sum, or 61 guineas payable in two instalments of 31 and 30 guineas respectively.

For prospectus and further information, application should be made to the Dean.

The composition fee for sons of registered medical practitioners is 105 guineas, and the fee, by instalments, 115 guineas. For dental students. 55 guineas in one sum, or 61 guineas payable in two instalments of 31 and 30 guineas respectively.

ST. GEORGE'S HOSPITAL.—This hospital is situated in the West End, facing Hyde Park. It contains 351 beds, and special wards for ophthalmic cases and diseases of women.

Appointments.—Eight house physicians and eight house surgeons, entitled to reside and board in the hospital free of expense; twelve general assistants, six assistants in the special departments. Candidates for the above offices are selected quarterly by competition from among the perpetual pupils, sixteen pupils being in office at any one time. Obstetric assistant with a yearly salary at the rate of £50 and board and residence in the hospital; curator of the museum with a salary of £200; assistant curator with a salary of £100; two medical registrars, with salaries of £200 per annum; a surgical registrar with a salary of £200 per annum; an administrator of anæsthetics with a salary of £50 and two with salaries of £30 per annum; a surgery officer with a salary of £100 a year; two or more demonstrators of anatomy with a salary of £50 each; and assistant demonstrators. All offices are open to candidates without additional fee.

By arrangement with the University of London, all students for the first, second, and third years of the curriculum carry out the necessary courses of instruction at either King's College or University College. The entire teaching of the school is devoted to clinical subjects.

There are two scholarships open to University students, particulars of which will be furnished by the Dean.

Fees.—For first year, £21 or £26 5s., according to the course. For second and third years, £57 15s. in one sum or £63 in two instalments. Students entering their names on the books before commencing the preliminary or intermediate subjects pay no entrance fee. Entrance fee, 10 guineas; annual composition fee, 30 guineas.

GUY'S HOSPITAL.—This hospital is situated on the Surrey side of London Bridge, and contains 602 beds in constant occupation. There are special wards for ophthalmic and obstetric cases, eight beds in the latter being appropriated for difficult cases of labour. Some beds have also been set apart for diseases of the ear and throat, and an "isolation" ward for cases of infectious diseases arising in the hospital has been constructed. An obstetric registrar and tutor and an ophthalmic registrar and tutor are appointed to augment the teaching in the special departments, in addition to those attached to the general surgical and medical wards. 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 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. A new museum for pathological specimens and additional lecture and class rooms were opened this year.

Appointments.—Eight house surgeons, eight house physicians, eight assistant house physicians, sixteen out-patient officers, sixteen assistant house surgeons, eight obstetric residents, two ophthalmic house surgeons, 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 and £50 in classics, mathematics, and modern languages. Open scholarships of £150 and £60 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. The following are the scholarships, prizes, and medals open to students of the hospital:—Junior prizes for general proficiency, £20, £15, £10; Hilton prize for dissection, £5; Michael Harris prize for anatomy, £10; Sands Cox scholarship for physiology, £15; Wooldridge prize for physiology, £10; Beaney prize in

pathology, £34; Golding-Bird prize in bacteriology, gold medal and £20; Treasurer's gold medal in clinical medicine; Treasurer's gold medal in clinical surgery; Beaney studentship in materia medica (tenable for 3 years), annually £31 10s.; Gull studentship in pathology (tenable for 3 or 5 years), annually £150.

Fees.—A new system for payment of composition fees has been recently instituted at this school. Particulars may be obtained on application to the Dean, Guy's Hospital, London Bridge, S.E.

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 is installed throughout.

Scholarships.—Two scholarships of the value of £100 each; a scholarship, value £50, is open to students of a British University who come up to London to complete their curriculum; and one of £40 for fifth year students. In addition, students may compete for the Carter, Todd, Tanner 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.

Special courses of lectures and practical instruction in the chemical, physical, physiological, and other laboratories have been arranged for students preparing for preliminary scientific, intermediate, M.B., and other examinations of the University of London.

F.R.C.S. Examinations.—Special classes are arranged for the final F.R.C.S. examinations. Further particulars can be obtained from the Dean.

London Hospital.—This hospital is the largest in Great Britain, containing, as it does, 929 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.

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 and class rooms for D.P.H. work are now open.

Appointments.—The "House" appointments, which are numerous, are made without fee of any kind, and all resident officers are provided with free board and rooms, and in some instances with salary also.

Fees.—Perpetual fee for lectures, demonstrations and hospital practice, payable in three instalments of 45, 45, and 40 guineas at the commencement of the first, second, and third years respectively, 130 guineas; or, if in one payment, 120 guineas. Fee for students entering in their third year (their first and second years having been spent at a recognised medical school, elsewhere) 60 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.

Note.—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 or for hospital practice. Residential accommodation is obtainable at a very reasonable rate close by, or in the suburbs a few minutes' distant by train. Fuller particulars can be obtained of the Warden, Mr. 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. The new wing, the ground-floor of which, comprising the new out-patient department, was opened in 1898, is now completed, and will be opened as soon as funds will permit; this will raise the number of beds to 350, clinical laboratory, and a clinical theatre. A new X-ray Department has recently been established in the Out-patient Department of the hospital. The Athletic Ground (eight acres) is situated at North Kensington, and is easy of access from the hospital. During the past year a Department for Therapeutic Inoculation has been instituted under Sir Almroth Wright, F.R.S., the work being carried on in two special laboratories in the Museum Buildings.

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 anæsthetists 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. One scholarship in natural science, of the value of £78 15s., and two of £52 10s., under the same conditions. Two scholarships, each of 60 guineas, open to students from any British University. The scholarships will be awarded by examination on September 25th, 26th, and 27th.

Fees.—Fee for attendance on the full five years' curriculum of hospital practice and all lectures, demonstrations, and special tutorial classes, £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.—A complete course of instruction in chemistry, physics, and biology, recognised by the University of London as an approved course for internal students, is held throughout the year. Students may join in October, January, or April.

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, aural, skin, dental, children's diseases, and electrical treatment (X-ray and Finsen light). Wards are also devoted to cases of uterine disease. 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 £75 in Arts and Science respectively. One entrance scholarship of the value of £50, open to Oxford and Cambridge students only. (Subjects—Anatomy and physiology, including histology.) "Emden" Cancer Research Scholarship, £100. "Richard Hollins," Research Scholarship, £105. 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 and scholarship, value £55, in surgery and

surgical anatomy; the Leopold Hudson prize, value 11 guineas, in surgical pathology, including bacteriology; Freeman scholarship, £30, in obstetrics and gynæcology; an exhibition of 10 guineas for anatomy and physiology to second years' students 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. 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 is 145 guineas. For those who have passed the preliminary science examination 120 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 medical school attached, is situated on the southern Embankment of the Thames, facing the Houses of Parliament and contains 602 beds, in constant 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 subjects of the medical curriculum. There is a large library and reading-room, and a very complete museum and gymnasium.

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 resident casualty officers at a salary of £100 per annum. 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, four house physicians to out-patients, four house surgeons, four house surgeons to oui-patients, two obstetric house physicians, two ophthalmic house surgeons are appointed each six months, and eight clinical assistants in the special departments each three months.

Scholarships, Prizes, &c.—Three entrance scholarships are offered for competition in September, *viz.*, one of £150 and one of £60 in chemistry, physics, and biology at the commencement of the second year; one of £50 open to University students who have passed in anatomy and physiology, for a medical degree in any of the Universities of the United Kingdom, and have not entered as students in any London Medical school. 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, and the Louis Jenner research scholarship, £60, for pathological research.

Special courses of instruction for the Preliminary Scientific and Intermed., M.B.Lond., for the Oxford and Cambridge examinations, and for the Primary and Final 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 may be obtained on application to Mr. G. Q. Roberts, Secretary of the Medical School.

UNIVERSITY COLLEGE AND HOSPITAL.—The hospital with college opposite are situated in Gower Street, not far from Euston railway terminus. The number of beds available for teaching purposes is *277*.

The new buildings for University College Hospital, completed by the generosity of the late Sir Blundell Maple, Bart., are now completed, and will be opened by H.R.H. the Duke of Connaught, on Tuesday, November 6th, 1906.

The new buildings for the Medical School, now in course of erection through the generosity of Sir Donald Currie, will be ready shortly, and will contain accommodation for undergraduate and post-graduate students in all departments of medical study subsequent to the intermediate course.

Appointments.—Eight house physicians, eight 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 scholarship of the value of 135 guineas, and two exhibitions of 55 guineas each, and the Epsom free medical scholarship for proficiency in science, the subjects being those of the Preliminary Scientific Examination of the University of London, and two of 80 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 £105 a year; Filliter exhibition for proficiency in pathological anatomy, value £30; Erichsen prize, operating case, value £10 10s., awarded for practical surgery; Dr. Fellowes' 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.

Composition Fees.—The following have been grouped to meet the requirements of the various examining boards: A.—For the Courses required by the University of London. 1. For the Preliminary Scientific course: 25 guineas, entitling to one attendance. 2. For the Intermediate Course: 60 guineas, if paid in one sum; 62 guineas if paid in two instalments. 3. For the Final M.B., B.S. Course: 80 guineas, if paid in one sum; 82 guineas, if paid in two instalments. This course of instruction is also suitable for the corresponding examinations at the Universities of Oxford, Cambridge, and Durham.

B.—For the Medical education required by the Examining Board in England and the Society of Apothecaries: 4. For the Course required for the First Examination: 30 guineas entitling to one attendance. 5. For the Second: 50 guineas, if paid in one sum; 51 guinesa, if paid in two instalments. 6. For the Course required for the Third Examination: 80 guineas, if paid in one sum; 82 guineas, if paid in two instalments.

The composition fee in each case entitles to attendance on Lectures and Hospital Practice during three years.

C.—For Dental Students. Composition fee for the Courses required for the L.D.S., 65 guineas; or exclusive of chemistry, practical chemistry, physics, and materia medica, 50 guineas.

Students may repeat attendance at the Courses in chemistry and physics for £3 3s. (inclusive) and in elementary biology for £2 2s.

It should be noted that under the arrangement with the University of London, that body controls the medical science section of the medical school now, while the advanced medical subjects, that is the subjects after the intermdiate course, are controlled by the University College Hospital Medical School.

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 £50 per annum; two house physicians, three house surgeons, one assistant house physician, one assistant house surgeon, and a 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. University scholarships, £40 and £30; subjects, anatomy and physiology. Natural science scholarship, £60, subjects, same as for Prel. Sci. of University of London. Natural science scholarship, £40, subjects, 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, University scholarships, £40 and £30, subjects same as in winter session. (*c*) Prizes, to be competed for by unqualified men. Chadwick, 20 guineas for students of any year not exceeding fifth. Bird medal and prize, £14 for students who have completed fourth winter session. Sturges prize in clinical medicine, £10, clinical surgery prize, £5. And class prizes in the various subjects.

Fees.—(*a*) For course required by Conjoint Board. In one payment of 120 guineas, or two payments of 65 guineas each, payable on entrance and at the commencement of second year respectively, or by six payments, distributed over six sessions, of 24 guineas each. (*b*) For the entire course of the University of London the composition fee is 140 guineas. 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 each.

LONDON SCHOOL OF MEDICINE FOR WOMEN (ROYAL FREE HOSPITAL).—The school is situated in Hunter Street, Brunswick Square, W.C., and the Royal Free Hospital is in Gray's Inn Road, close to the School. The school was re-built in 1898, and the laboratories are fully equipped for all the work required for the preliminary Scientific and Intermediate M.B. examinations of the University of London. A course of study is specially arranged for the work required by the Conjoint Colleges of Scotland and the Society of Apothecaries. Students are also prepared for the examinations of the University of Durham and other Universities. The Royal Free Hospital contains 165 beds available for clinical study; and there is a large out-patient and casualty department. In addition to the ordinary systematic lectures at the school, clinical lectures are given at the hospital in medicine, surgery, obstetrics, ophthalmology and dermatology. Students hold clerkships and dresserships in each department.

Appointments.—One house physician, one house surgeon and a senior and junior resident obstetric assistant are appointed yearly. There are also many non-resident appointments including the anæsthetist and assistant anæsthetists, assistant and clinical pathologists, medical and surgical registrars, curator of museum and clinical assistants.

Scholarships.—A School Scholarship of £30, and a St. Dunstan's Medical Exhibition of £60 yearly for three years, extendible to five years, are offered annually. In addition to these there are various scholarships and prizes offered from time to time, including the Bostock Scholarship of £60 a year for two years, extendible to four years; the Stuart Mill Scholarship of £30 a year for four years; the John Byron Bursary of £20 a year; and the Mabel Webb Research Scholarship of £30 a year.

Fees.—The fee for the Intermediate and Final M.B. University of London course is £135 in one sum, or £145 in the following instalments:—first year, £45; second year, £40; third year, £40; fourth year, £20. The fee for the Preliminary Science classes is £25. The fee for the course for the Conjoint Colleges or Society of Apothecaries, including Elementary Science, is £140 in one sum, or in the following instalments:—first year, £50; second year, £40; third year, £30; fourth year, £20. Further particulars can be obtained from the Secretary, Miss Douie, M.B., 8, Hunter Street, W.C.

EXTRA-ACADEMICAL INSTITUTIONS IN LONDON.

ROYAL INSTITUTE OF PUBLIC HEALTH.—The Royal Institute of Public Health, 37, Russell Square, was founded in the year 1886, with the object of obtaining the registration of public health diplomas and the further statutory requirement that all Medical Officers of Health should possess such a qualification, by which means it has succeeded in placing at the head of every public health administration in the Kingdom, a properly trained and specially qualified medical officer. The Council, with the object of providing a Central Institution in London, not only for instruction for the diploma and for scientific work in connection with public health, but also one to which those engaged or interested in preventive or tropical medicine may resort for purposes of reference or social intercourse have acquired large and important premises for the purposes of the Institute, providing a common room for the use of Fellows and Members, a lecture room, a reference library, laboratories for bacteriological and chemical and physical research, and laboratories in which the course of instruction for the diploma in public health can be taken. These laboratories have been fitted up with all modern improvements, and are intended to supply a want long felt in London, and to place the Metropolis, in this respect, on an equality with many provincial and University cities.

The Institute is recognised as a public educational institution by the University of London, and its courses of instruction by the Universities and the Royal Colleges of Physicians and Surgeons.

In pursuance of the above objects, the Institute publishes monthly *The Journal of Preventive Medicine.*

Facilities are also afforded for municipal authorities, private medical practitioners, and others to obtain bacteriological and chemical reports.

The Institute is under the patronage of His Majesty the King, and the Right Hon. Lord Strathcona and Mount Royal is President. The teaching staff consists of the Principal, Professor William R. Smith, M.D., D.Sc., F.R.S.E., Barrister-at-law; Demonstrator of Bacteriology, Carl Prausnitz, M.D., Breslau; Demonstrator of Chemistry, Mr. C. E. Harris, Ph.D.; Director of Parisitological Dept., Dr. Louis Sambon.

The next annual Congress (1907) will take place at Douglas, Isle of Man, under the Presidency of the Right Hon. Lord Raglan, Lieutenant-Governor of the Island.

THE ROYAL DENTAL HOSPITAL.—The teaching and hospital practice at this institution (situated in Leicester Square) are recognised by the various examining bodies. The new hospital was opened in March, 1901, and is complete in every detail with modern appliances, and the school is the most thoroughly equipped of any in the United Kingdom. The clinic of the hospital is unrivalled, no less than 98,588 cases being treated in 1905. The following scholarships and prizes are open to all full term students:—Entrance scholarship, of the value of £20, awarded in October. Subjects: Chemistry and dental mechanics. Saunders scholarship, of the value of £20, awarded to the student obtaining the highest aggregate number of marks in the various class examinations. Storer-Bennet research scholarship of the value of £50, awarded once in three years. Robert Woodhouse prize, of the value of £10, for

practical dental surgery. Class prizes are awarded by the various lecturers.

Provision is made for teaching mechanical dentistry as required by the Royal College of Surgeons, the pupils being under the guidance of the staff of dental surgeons assisted by specially appointed demonstrators.

The school contains an excellent library and a well-arranged museum.

Fees.—For the two years' hospital practice and lectures as required by the Royal College of Surgeons of England, the fee is £53 3s. in one instalment, or £55 13s. in two yearly instalments. The fee for the complete curriculum, namely, two years' instruction in mechanical dentistry and two years' hospital practice and lectures, is £150 if paid in one instalment, or 150 guineas if paid in three instalments of 50 guineas. For one year's instruction in mechanical dentistry the fee is 50 guineas. For one year's hospital practice, £21. The necessary course of two years at a general hospital can be taken simultaneously with that at the Royal Dental Hospital. Further particulars can be obtained on application to the Dean.

NATIONAL DENTAL HOSPITAL.—This institution is centrally situated (Great Portland Street, W.), and excellent teaching facilities and hospital practice are here obtainable, special demonstrations being given by members of the staff. There are also a mechanical laboratory, bacteriological laboratory, museum, students' common room, a metallurgical laboratory, extraction and stopping rooms, lecture hall, regulations room, &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 2nd. The medical tutors hold special classes before each college examination. The prizes include two entrance exhibitions, value £40 and £20, and the Rymer prize of £5 5s., the examinations for which are held in May and October. The fee for two years' hospital practice required by the curriculum, including lectures, is £40. (See advt.)

LONDON SCHOOL OF TROPICAL MEDICINE (University of London).—This Institution is the outcome of a suggestion by the Right Hon. Joseph Chamberlain, H.M. late 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 great numbers from the Tropics, affording immediate opportunity 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. Information as to fees, &c., can be obtained of the Dean or the Secretary.

Medical students are admitted to the practice of 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, Hammersmith. — This contains 175 beds, and has an extensive out-patient department. Dresserships and clinical clerkships may be obtained. Two house surgeons and two house physicians are selected every six months. There are special departments for diseases of the throat, nose and ear, skin, women and children, and deformities. Electrical and X-ray departments have also been added. The practice of this hospital is reserved exclusively for medical men, junior students not being admitted.

GREAT NORTHERN CENTRAL HOSPITAL, Holloway Road, N.—This institution has been greatly enlarged, contains 167 beds, cases in various special departments are treated, and the hospital is now recognised for study during the fifth year by the Conjoint Board. 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.—In this Royal institution only cases of lunacy are received, and students intending to pursue this special branch have the best possible opportunities afforded here. The hospital contains 300 beds, and 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. Post-graduate lectures are also given.

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.

LONDON TEMPERANCE HOSPITAL.—The hospital contains 110 beds, and is conducted as its name implies on non-alcoholic principles by an excellent staff. 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, Kingsland.—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.

TOTTENHAM HOSPITAL, N.—This hospital contains medical and surgical wards and a ward for children, having in all 73 beds. There are special departments for gynæcological cases, diseases of the eye, ear, throat and nose, and skin diseases. It has now been authorised by the University of London to give certificates of post-graduate study for the M.D. and M.S. degrees.

HOSPITALS FOR CONSUMPTION.

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 321 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 four o'clock, save during the vacations. Terms, £2 2s. for three months; £5 5s. perpetual. This hospital is recognised by the Conjoint Board, the University of London, and the Apothecaries' Society.

MOUNT VERNON HOSPITAL, Hampstead and Northwood.—This institution, formerly called the North London Consumption Hospital, now carries on its work at Hampstead with 145 beds, and at Northwood with 100 additional beds, where treatment is carried out on the most modern lines, including the "open air" and other systems. Students are admitted to the practice of the hospital under certain conditions, and post-graduate courses are regularly delivered during the year.

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.

ROYAL HOSPITAL FOR DISEASES OF THE CHEST, City Road.—(80 beds.)—This hospital has been enlarged by the addition of a very complete out-patients'

department, and also by the erection of a new wing, which provides accommodation for 80 in-patients.

THROAT AND EAR HOSPITALS.

HOSPITAL FOR DISEASES OF THE THROAT, Golden Square, W.—This hospital has been recently rebuilt and contains 40 beds. Clinical instruction is given daily in the Out-patient Department on diseases of the nose, throat, and ear, and systematic courses of lectures are given during the winter session. There are nine clinics weekly, and an annual out-patient attendance of nearly 50,000. Major and minor operations daily (Mondays excepted) in different theatres. Four senior and forty-two junior clinical assistants are appointed from among the students to assist the surgeons. Students are admitted to the practice of the hospital at the following fees:—Three months, £5 5s.; six months, £7 7s.; perpetual attendance, £10 10s. Further details can be had by applying to the Dean.

CENTRAL LONDON THROAT AND EAR HOSPITAL, Gray's Inn Road.—In addition to the in-patient department, which is now undergoing enlargement by the addition of more beds and an operating theatre, there is an extensive out-patient department in which clinical demonstrations are given daily at 2.30 p.m. Full facilities are afforded for acquiring sound practical experience of the subjects. Twelve clinical assistants—who must be duly qualified—are elected to assist the surgeons. Operation days—Tuesdays and Fridays, 2 p.m. Fees for the three months' attendance, £3 3s.; six months', £5 5s. Full details of this institution and post-graduate work can be obtained on application to the Dean.

METROPOLITAN EAR, NOSE, AND THROAT HOSPITAL.—The hospital was founded in 1838, and is situated in Grafton Street, Tottenham Court Road. The out-patient department is open daily at 2.30 p.m. to practitioners and students for acquiring clinical instruction and technical knowledge. Operations are performed on in-patients on Tuesdays, Wednesdays, and Thursdays at 9 a.m. Fee for one month's attendance at the hospital one guinea, and for three months two guineas. During the forthcoming session demonstrations will be given by members of the staff on the pathology and treatment of diseases of the ear and respiratory passages. Short practical classes will also be held in clinical pathology and surgical anatomy. Weekly clinical lectures are given by the staff on the special disease treated at the hospital.

WOMEN AND CHILDREN.

THE HOSPITAL FOR WOMEN, Soho Square.—The hospital contains 61 beds. In connection with this institution there is now an organised school of gynæcology 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, and certificate, £8 8s.

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 gynæcology. The success of the staff in this department has gained for them a European reputation. There are 47 beds.

ROYAL WATERLOO HOSPITAL FOR CHILDREN AND WOMEN.—This important institution, situate in South London, has been in a transition state for some time past, having been partly rebuilt and appointed on ambitious lines, and when completed, which it is expected to be shortly, will contain 200 beds.

HOSPITAL FOR SICK CHILDREN in Great Ormond Street, Bloomsbury, W.C., and Cromwell House, Highgate.—Fee for three months' attendance, £2 2s.; perpetual, £3 3s. 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 is open to pupils of the different hospitals and medical schools of London and medical practitioners on conditions to be ascertained from the Secretary.

EYE HOSPITALS.

ROYAL LONDON OPHTHALMIC HOSPITAL, formerly in Moorfields, and recently rebuilt in the City Road, is the largest hospital devoted to this specialty in Great Britain, and contains 138 beds. Students and practitioners are admitted to the practice daily at 9 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, adjoins Charing Cross Hospital in King William Street. It has about 40 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 two cots. Fees, £2 2s. for three months, £3 3s. for six 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.

SKIN HOSPITALS.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN.—Out-patient department, Leicester Square; In-patient department, Uxbridge Road, W. This hospital has a well-equipped in-patient department, with 50 beds. It has a School of Dermatology at 49 Leicester Square, which is 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 on Thursday, October 4th, at 6 p.m., in the Lecture Room of the Hospital, Leicester Square. The subject of the opening lecture will be "Baldness." The Out-patient Department has just been rebuilt at a cost of £10,000, and contains a spacious laboratory and special electrical department which can be seen in operation on Monday, Thursday and Friday afternoons. Clinical demonstrations are given every Friday (Dr. Morgan Dockrell), at 2 p.m.; Wednesday (Dr. Saville, at 3 p.m.; and Tuesday (Dr. Eddowes), at 2 p.m. on Selected Cases (See Advt.)

One of the oldest institutions of the kind is the Western Skin Hospital (Great Portland Street), which was started as long ago as 1851. 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 department 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.

METROPOLITAN POST-GRADUATE INSTITUTIONS.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC.—This institution affords to medical men special facilities for acquiring technical skill, and advancing their medical and scientific knowledge. The building, which is large and commodious, is situated in Chenies Street, Gower Street, and contains lecture and consulting rooms, pathological and clinical laboratories, Röntgen ray room, an ophthalmoscope room, a library and museum, and reading and smoking rooms. *Cliniques*, at which patients are shown, are given every day of the week except Saturday, at 4 p.m. Lectures on Medicine, Surgery, and other allied subjects are delivered on Mondays, Tuesdays, Wednesdays, and Thursdays at 5.15 p.m. Four sessions of practical classes, each lasting six weeks, and a vacation session of three weeks' duration, are held during the year, the subjects taught comprising ophthalmology, otology, clinical microscopy, laryngology, urinary analysis, gynæcology, applied anatomy, nervous diseases, and practical X-ray work. There are, in addition, extra-mural classes in operative surgery and practical anatomy with dissecting.

A complimentary ticket for three days, admitting to *cliniques* and lectures, is issued to any medical practitioner on personal application at the college. The annual subscription for medical practitioners of either sex, holding qualifications granted in any of H.M.'s dominions—wherever resident—is One Guinea. Full information may be obtained from the medical superintendent, Mr. Hayward Pinch, F.R.C.S., 22, Chenies Street, W.C.

WEST LONDON POST-GRADUATE COLLEGE.—The West London Hospital, Hammersmith Road, W., contains 159 beds; the post-graduate course was started in 1895, and this is the original post-graduate college in London attached to a general hospital. Instruction is given in the out-patient department daily at 2.15 p.m. by the assistant physicians and assistant surgeons. The physicians and surgeons attend daily at 2.30 p.m., when post-graduates can accompany them in their visits to the wards. Operations are performed daily at 2.30 p.m. There are lectures every evening at 5 p.m. (Saturdays excepted). Special classes are held in bacteriology, diseases of the eye, throat, X rays, anæsthetics, intestinal surgery, etc.

Fees.—The fee for the hospital practice including all the ordinary lectures and demonstrations, is £1 1s. for one week; £2 2s. for one month; £5 5s. for three months; £8 8s. for six months; £12 12s. for one year, and £25 for a life ticket. A course of attendance on either the medical or surgical practice alone may be taken out for the fee of £3 3s. for three months. The fee for three months' attendance in any one special department, other than medicine or surgery is £2 2s. A prospectus containing full particulars will be forwarded on application to Mr. L. A. Bidwell, Dean.

NORTH-EAST LONDON POST-GRADUATE COLLEGE.—This post-graduate school is established in connection with the Tottenham Hospital, N., which is recognised by the University of London as a place of post-graduate study for the M.D. and M.S. degrees. Facilities are here afforded to qualified medical practitioners for taking part in the work of an active general hospital, and for attending demonstrations of various branches of medicine, surgery and gynæcology, with opportunities for clinical instruction in diseases of the eye, ear, throat, nose, skin, in fevers, psychological medicine, the administration of anæsthetics, radiography and dentistry. Cliniques, lectures and demonstrations are given by members of the teaching staff in the lecture room, in the wards, in the various out-patient departments, and in certain affiliated institutions. Operations are performed every afternoon of the week, except Saturday. Special classes, the attendance at which will be limited, are arranged in gynæcology, the surgical diseases of children, including orthopædic surgery, diseases of the throat, nose and ear, diagnosis of diseases of the nervous system, ophthalmoscopy and refraction, analysis of gastric contents, clinical examination of the blood, diseases of the skin, abdominal surgery, radiography, bacteriology, and medical electricity. The fee for a three months' course of study, which may be begun at any time, in any single department, is one guinea. A fee of three guineas admits to the whole practice of the hospital for a similar term (one month, 2 guineas), and a perpetual ticket for the practice of the hospital may, for the present, be obtained on payment of a fee of 5 guineas. Additional information with a syllabus of lectures demonstrations, and special classes, may be obtained from the Dean of the Post-Graduate College, Dr. A. J. Whiting, 142, Harley Street, W.

PROVINCIAL MEDICAL SCHOOLS.

BRISTOL UNIVERSITY COLLEGE.—FACULTY OF MEDICINE.—The lectures and instruction given in the Faculty of Arts and Science of University College, Bristol, are adapted to the various preliminary science 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. Well-equipped laboratories are now provided for anatomy, physiology, bacteriology, and pathology. Students of the college are admitted to the clinical practice of those very important and well-equipped institutions, the Bristol Royal Infirmary and the Bristol General Hospital. The infirmary and the hospital comprise between them a total of 470 beds, and both have very extensive out-patient departments, and 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 40 beds. The total number of beds available for clinical instruction is therefore 614. 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. There are one medical entrance scholarship, value £75, awarded annually, two Martyn memorial scholarships (pathology and morbid anatomy) of £10 each, the Tibbits memorial prize, value £9, for proficiency in practical surgery, Henry Marshal prize, £12; Clarke Scholarship, £15; Sanders Scholarship, £22 10s.; 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 and hospital practice, and including all fees, except vaccination and small charge for board of midwifery student, 133 guineas. If in two instalments, 80 guineas at first session and 60 guineas in the beginning of the second year. Dental composition fee, 75 guineas, including all lectures, practical classes, and hospital practice. Clinical fees (if the composition fee has not been paid)—Surgical practice, one year, 12 guineas; perpetual, 20 guineas. Medical practice, 20 guineas; perpetual, medicine and surgery, 40 guineas.

Prospectus and further information on application to the Dean, Professor Edward Fawcett, M.D.

SHEFFIELD UNIVERSITY COLLEGE.—*Faculty of Medicine.*—The Winter Session, 1906-7, will commence in the new University building on Wednesday, Oct. 3rd.

The University was opened on July 12th, 1905. by the King. The plan of the buildings is that of four blocks, enclosing a quadrangle, 154 ft. by 110 ft. The medical department occupies the entire north wing overlooking the quadrangle on one side and Weston Park on the other. The anatomical department occupies about two-thirds of the upper ground floor. The dissecting room has been designed and equipped to meet all modern requirements of the student of anatomy. The lecture theatre is provided with a lantern of modern type illuminated by the electric arc. The anatomical museum has a gallery which is set apart chiefly for anthropological and morphological collections. The floor space affords accommodation for bones, models, and spirit specimens mounted in glass jars. Research laboratories and private rooms are provided for the professors and demonstrators. The department of physiology occupies the first floor. In the general laboratory, a large and well lit room, accommodation is provided for microscopical work at a bench running the full length of the laboratory beneath the windows; the space behind is occupied by movable tables, each equipped for the purposes of experimental work, an arrangement which enables the students to work either singly or in small groups. The fixed equipment of the room

is designed to provide power for machinery, gas, electricity, and water wherever the tables may be situated. The second laboratory for chemical physiology is fitted with benches, fume cupboards, &c. In addition a considerable portion of the space in this room is devoted to and equipped for work of a more advanced type. Opening into this laboratory are a balance room and two rooms fitted for photography, spectroscopy, &c. Opportunities are afforded for research work in three special rooms. One, beautifully lighted by windows in two of its walls, is equipped for general research, another a room which can be darkened for optical work and photographic recording; and a third in the basement is provided with the solid pillars, &c., necessary for work with delicate instruments requiring great stability. In the lecture theatre, a large amount of space has been left for the demonstration of experiments, and is equipped with the larger pieces of apparatus necessary for such work. The whole upper storey of the medical block is occupied by the Department of Pathology. The students' laboratory, a very large and lofty room, is fitted and equipped with every modern appliance for microscopical and bacteriological work. The incubating room, built into the centre of the pathological department is so arranged that it may be kept at a constant temperature, thus replacing the ordinary incubating ovens. The museum is spacious and is furnished with a gallery. Research laboratories are provided. On the upper ground floor are well-furnished lecture rooms for other subjects, and the materia medica museum. The library of the Sheffield Medico-Chirurgical Society, to which students are admitted, is situated on the ground floor overlooking the quadrangle.

Hospital practice is taken out at the Royal Infirmary (255 beds) and at the Royal Hospital (165 beds), both of which institutions have special departments for diseases of the eye, ear, and throat, and skin. At the latter there is also an extensive dental department.

Composition fee, £45; or in two payments, viz., £26 on entrance, £22 within twelve months afterwards.

Composition fee for medical and surgical hospital practice, £36 5s.; or in two payments, viz., £18 18s. on entrance and £18 18s. within twelve months afterwards.

Composition fee for lectures and practical courses, £80 in one payment or in three instalments of £24, £28, £28.

An Entrance Scholarship of the approximate value of £100 is awarded on the results of the Matriculation Examination of the Joint Matriculation Board held in July.

Students of either sex are admitted to the degrees of the University.

The Kaye scholarship, for second year students, natives of Sheffield, is awarded annually, under certain regulations. Gold Medal for clinical medicine and clinical surgery; medals and certificates awarded annually.

UNIVERSITY OF WALES, 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 examinations in these years, 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 £41 10s., or by paying £20 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.

In the case of medical students, attendance on the class of hygiene and public health is accepted by the Universities of London and Cambridge, and by the Conjoint Examining Board of England

Courses of lectures to midwives, adapted to the requirements of the Central Midwives' Board, under the Midwives Act, are commenced in October, January, and April. The lectures are suitable both for pupil midwives and practising midwives, as well as for nurses who desire to enter for the examination for certification under the Act.

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, or from the Dean of the Medical Faculty.

UNIVERSITY OF LEEDS.—This school of medicine, attached to this recently incorporated University, was originally founded more than seventy years ago as the Leeds Medical School. The building, erected on a site contiguous to the infirmary, and opened twelve years since, 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 Leeds General Infirmary, one of the largest in the United Kingdom, having 524 beds, with a staff of physicians and surgeons of considerable eminence. 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 is a large dispensary, a large hospital for infectious diseases, a hospital for women and children, and a maternity home, all of which are open to students of the school.

Scholarships, Prizes, &c.—(1) An entrance scholarship of £71 0s. 6d. There is also a Hardwick prize in clinical medicine, a M'Gill prize in clinical surgery, each of the value of £10. Thorp prizes of £10 and £5 in forensic medicine and hygiene, and a Scattergood prize of £5 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 £71 0s. 6d. 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, 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 offered annually by the Infirmary.

Degrees and Diploma in Dental Surgery are obtainable at this university, being Bachelor of Dental Surgery (B.Ch.D.), and Master of Dental Surgery (M.Ch.D.). Candidates for the degree of Bachelor of Dental Surgery are required to have passed the Matriculation Examination, to have pursued thereafter approved courses of study for not less than five academic years, two of such years at least having been passed in the University subsequently to the date of passing Parts I. and II. of the first examination, and to have completed such period of pupilage or hospital attendance, or both, as may be prescribed by the Regulations of the University. No candidate shall be admitted to the degree who has not attained the age of twenty-one years on the day of graduation.

Candidates for the diploma in Dental Surgery are required to present certificates showing that they have attained the age of twenty-one years, that they have attended courses of instruction, approved by the University, extending over not less than four years and that they have completed a pupilage of three years, two of such years at least, having been taken before the First Professional examination. Candidates are required to satisfy the Examiners in the several subjects of the following examinations: A preliminary examination in Arts; a Preliminary examination in Science; the First Professional examination; and the Final examination.

LIVERPOOL SCHOOL OF TROPICAL MEDICINE.—This school, which has for its object research into Tropical Diseases and Improvement in Tropical Sanitation, was founded in Liverpool in 1899 by Sir Alfred Jones, K.C.M.G., who is the chairman of the school. The research work of the school is carried on at the Johnston Laboratories, in Liverpool University. The clinical work is carried on at the Royal Southern Hospital. A special feature of the work of the Liverpool School of Tropical Medicine has been the despatch of a large number of important medical expeditions to various places in the tropics, especially West Africa. Although the School has only been in existence for a short time it has already sent over a dozen of these expeditions. In addition, the School has issued a number of valuable publications and monographs on subjects connected with tropical diseases. The Duke of Northumberland, K.G., is Hon. Vice-President; Sir Alfred L. Jones, K.C.M.G., Chairman of Council; and Mr. Wm. Adamson, Vice-Chairman; and the following is the school staff. Sir Alfred Jones, Professor Ronald Ross, C.B., F.R.S., F.R.C.S.; Walter Myers Lecturer, J. W. W. Stephens, M.B.Cantab; Lecturer in Economic Entomology and Parasitology, R. Newstead, A.L.S., F.E.S. Lecturer in Tropical Diseases of Animals, H. E. Annett, M.D.; Director of Tropical Research at Runcorn, J. L. Todd, B.A., M.D., C.M. McGill; Assistant Lecturers, H. Wolferstan Thomas M.D., C.M. McGill, Anton Breinl, M.U., Dr. (Prag.) Demonstrators and Research Assistants, Allan Kinghorn, M.B., E. N. Tobey, A.B., A.M., M.D. Dean: Professor Rubert Boyce, M.B., F.R.S. Hon. Secretary A. H. Milne, B 10, Exchange Buildings, Liverpool.

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 130 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 220 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 190 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.

LIVERPOOL NORTHERN HOSPITAL, which has recently been rebuilt, now contains 246 beds, and is completely equipped with the most modern appliances. 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, £6 6s.; three months, £4 4s.; practical pharmacy, £2 2s.

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.

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.

ROYAL BERKSHIRE HOSPITAL.—The town of Reading, in which this hospital is situated, has a very large working-class population, and excellent opportunities for clinical instruction in the wards and extensive out-patient department are afforded here. It contains 160 beds, a splendid library, in which the Reading Pathological Society holds its mettings.

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 120. The fees are the same as at all similar institutions,

ROYAL DEVON AND EXETER HOSPITAL, Exeter.—The hospital contains 200 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.

NORTHAMPTON GENERAL HOSPITAL.—This hospital contains 174 beds; it has been recently enlarged and re-arranged. Non-resident pupils are received and have every opportunity of acquiring a practical knowledge of their profession. The fee is £10 10s.

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.

A PRESENTATION to the anti-vivisectionist leader, Dr. Walter Hadwen, has just taken place. In recognition of Dr. Hadwen's valuable services to the anti-vivisectionist cause, a beautiful silver rose-bowl and a sum of money were handed to him by the subscribers.

BY electing Miss Frances Ivens, M.B., M.S., London, the Stanley Hospital has the distinction of receiving on its honorary medical staff the first lady doctor to be appointed to a general hospital in Liverpool.

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.

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 of Physic, Dub. Univ. ...	£122 6s. 6d.
Royal College of Surgeons School	£124 19s.
Catholic University School ..	£124 19s.
Queen's College	About £110

COST OF DIPLOMAS OR DEGREES.

Dublin University	£27 (to this must be added £83 4s., the cost of obtaining an Arts degree).
Royal University	£15.
Conjoint Royal Colleges ..	£42.
Apothecaries' Hall	£22 1s.

Thus, the absolute payment will amount to somewhere between £125 and £232 10s. 6d. 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" although not officially recognised, occupies a position almost identical with that of the extra-mural instruction in other schools. Its cost must be reckoned among the expenses of the course, for, while not essential, it has become customary for almost all students to obtain aid in their studies in this way. As a rule, this private instruction costs about £5 5s. for each of the four examinations.

The above sum, or something like it, may be expended by the student or his parent in paying for lectures, &c., and examination fees as they fall due, and there is no difficulty in obtaining the needful information for his guidance if he likes to pay for his course in this fashion.

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 remembered 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 act 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, unless, as is usually the case, this duty is undertaken for him by the school registrar. 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 may lose credit for his work.

The only preliminary examination held specially for medical students is that 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 Examination passes in the required subjects, and all other examinations recognised by the General Medical Council are accepted as equivalent.

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 a 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, including vulgar and decimal fractions ; (*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 IRISH LICENSING BODIES.

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 conjoint Royal Colleges of Physicians and Surgeons. *c*. Those who take their qualifications at the Royal University of Ireland, where graduation in Arts is not necessary. *d*. Those who take the licence of the Apothecaries' Hall. *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 who have been for at least five academic years on the books of the Medical School, and the higher degrees of M.D., M.Ch., and M.A.O. to those who have held, or have been qualified to hold, for at least three years, the degree 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, £66 13s. 6d. ; Hospitals, £55 13s. ; Degree Fees, £27.—Total, £149 6s. 6d.

The expense of the B.A. degree, amounting altogether to £83 4s., should be added, making the total cost £232 10s. 6d.

Important new regulations come into force in the Summer Session of 1906. One of the main results of these will be to diminish the extent of the Arts course for medical students, while at the same time preserving

the advantage of an Arts education by rendering the attendance on certain lectures compulsory. Changes in the medical examinations will also take place, but the curriculum itself is practically unaltered.

In addition to its ordinary qualifications the University grants the following higher degrees :—

Doctor of Medicine.—To obtain this the candidate must have obtained the degree of M.B., or have been qualified to have obtained it for three years. He must then read a thesis before the Regius Professor of Medicine. Fee for this degree, £13.

Master of 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 this degree, £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 of obstetric medicine and surgery. He is then required to pass an examination in the following subjects :—Practice of midwifery, gynæcology, anatomy of female pelvis and elementary embryology, and clinical gynæcology. Fee for this degree, £5.

Diplomate in Medicine, Surgery, and Midwifery — Candidates for the diplomas in Medicine, Surgery, or Obstetric Science must be matriculated in Medicine, and must have completed two years in Arts and five years in medical studies. The course and examination is the same as for the degrees, 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. Fees for the diplomas in medicine, surgery, and midwifery, £21. A diplomate, on completing his course in Arts and proceeding to the degree of B.A., may become a Bachelor by attending the lectures on botany and zoology, passing the preliminary scientific examination in those subjects, and paying the degree fees.

Diploma in Public Health.—The candidate must be an M.D. or a Graduate in Medicine and Surgery of Dublin, Oxford, or Cambridge, 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.

Degree and Licence in Dental Science.—Candidates for the degree in dental science must have taken a degree in Arts, and must have had their names in the books of the Medical School for five years. Two examinations must be passed—namely, the Previous Dental at the end of the second year, and the Final Dental at the end of the fifth year. Candidates for the Licence are required to matriculate in Arts, but need not proceed further in the Arts course. The course of study is the same as for the degree with the exception that no lectures in pathology or bacteriology are required. The total fees for the licence, including the premium for Dental Mechanics (£100), are £200 17s., while those for the degree are about £210, to which must be added the cost of the B.A. degree.

Post-Graduate Classes.—A short post-graduate course is now given annually in July in connection with Trinity College Medical School. It includes special work on Diseases of the Eye, Nose, and Throat, Gynæcology, Diseases of the Skin, X-ray work, Medicine, Surgery (clinical and operative), and Clinical Pathology.

Royal Services School.—The object of this school is to prepare candidates for the Indian Medical Service, and Royal Army Medical Service. It is conducted on a comprehensive scale, and affords special opportunities for operating on the cadaver, and for the study of commentaries. Two sessions are held yearly, each lasting for about ten weeks.

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., B.Ch., B.A.O., and the higher degrees of M.D., M.Ch., and M.A.O. It also confers a Diploma in Public health and 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 October 1st.

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 previous examination, £1 ; for the degree examination, £2 ; for the diploma, £10.

In addition, the following degrees are granted :—

Diploma in Public Health.—Conferred only on graduates in medicine of the University of at least twelve months' standing. Fee, £2. Subjects.—Meteorology, bacteriology, chemistry, physics, vital statistics, hygiene, sanitary engineering, architecture and law.

The M.D. Degree.—Conferred only on graduates in medicine of the University of three years' standing. They must at the same time produce a certificate of having been, for at least two academical years, engaged in hospital or private, medical, surgical, or obstetrical practice, or in the military or naval medical service. The examination comprises medical diseases and the theory and practice of medicine, including pathology. Every candidate will be examined at the bedside, and be required to diagnose at least three medical cases, and prescribe treatment, and to write detailed reports on at least two cases to be selected by the examiners and to discuss the questions arising therefrom Fee, £5.

The M.Ch. Degree.—Conferred only on graduates in medicine of the University of three years' standing, and who can produce a similar certificate of practice to that required for the M.D. degree. The examination comprises surgery, both theoretical and operative surgical anatomy ; ophthalmology and otology Fee, £5.

The M. A. O. Degree.—Conferred only on graduates in medicine of the University of three years' standing, and who can produce a similar certificate of practice to that required for the M.D. and M.Ch. degrees. The examination comprises midwifery and diseases of women and children. Fee, £5.

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 exhibitions of £25, and two second-class of £15, and the Dr. Henry Hutchinson Stewart Medical Scholarships, value £10 a year for three years. The latter are awarded in psychological medicine, diseases of the nervous system and anatomy, physiology and pathology of brain, cord, and nerves. Competition among medical graduates of not more than three years' standing. Fee £2. Value £50 a year for three years.

Third Examination in Medicine.—Two first-class exhibitions of £30 each, and two second of £20 each.

Medical Degrees Examination.—Two first-class exhibitions of £40 each, and two second 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.

These examinations are held conjointly by the two Colleges. The course, as in other bodies, extends over five years, with examinations 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 curriculum has recently been revised, and made of a more practical nature. In common with the English Colleges, the subjects of the First Professional examination may be studied either at a medical school or at an institution other than a medical school recognised by the Colleges, after due inspection, for instruction in these subjects. 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. In the case of the Preliminary Examination seven clear days' notice must be given to the Secretary; fourteen days' notice is required from candidates for the Professional examination.

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 re-examination fees, which have to be paid in case the candidate fails to pass his examination.

The Conjoint Colleges also confer a diploma in Public Health, of which information will be found on page 276.

ROYAL COLLEGE OF PHYSICIANS.

This College issues a Licence in Medicine and a Licence in Midwifery to Registered Medical Practitioners.

Licence in Medicine.—The subjects of examination are:—Practice of Medicine, Clinical Medicine, Pathology, Medical Jurisprudence, Midwifery, Hygiene and Therapeutics.

Licence in Midwifery.—The subjects of examination are:—Gynæcology and Midwifery. A Registered Medical Practitioner of five years' standing is exempted from the examination by printed questions.

Fees.—Fee for the Licence to Practise Medicine £15 15s. Fee for the Licence to Practise Midwifery £5 5s.

Membership.—The Membership is open to University Graduates in Medicine and to Licentiates of the Royal Colleges of Physicians of the United Kingdom. The Examinations for Membership are held in January April, July, and October, and such other times as the President may appoint.

ROYAL COLLEGE OF SURGEONS IN IRELAND.

This College grants a licence in Surgery to registered medical practitioners. Candidates who hold registrable surgical diplomas, including the licence of the Apothecaries' Society of London, and the Apothecaries' Hall, Dublin, granted since October, 1886, are admitted to examination without further evidence of study, but candidates who hold medical qualifications only, including the L.S.A. and L.A.H., granted before October, 1886, will be required to produce certificates of two courses of lectures in anatomy and dissections, one course of practical histology, one course of lectures in surgery, and one course of operative surgery.

Candidates are examined in surgery, clinical and operative; surgical appliances; and ophthalmic surgery. The fee is £26 5s. The fee for a special examination is £31 10s.

A diploma in Midwifery is also granted after examination to registered medical practitioners. Candidates must produce evidence of (*a*) attendance on a course of lectures on midwifery and diseases of women and children in a recognised school; (*b*) attendance or six months' practice at a recognised lying-in hospital or recognised dispensary for lying-in women and children; and (*c*) of having conducted at least thirty labour cases. The fee for the examination is £15 15s.

Fellowship.—Candidates for the Fellowship of the College must enter their names with the Registrar at least a month before the date of examination, in order that the Council may decide whether to approve of the application. Examinations are held the third Mondays in February, May, and November. If the application is approved, the candidate will be admitted to the next sessional examination or to a special examination (except during the months of August and September) if granted by the Council. Candidates are divided into two grades:—

Grade 1.—Licentiates or graduates in surgery of less than ten years' standing.

Grade 2.—Licentiates or graduates in surgery of more than ten years' standing.

Students, not either Licentiates or Graduates in Surgery, are permitted to present themselves for the *Primary* Examination under Grade I.

Candidates in Grade 1 must pass two examinations—Primary (in anatomy and physiology) and Final (in surgery). Candidates in Grade 2 need pass but one examination in surgery, surgical anatomy, and surgical pathology.

Fees.—Grade 1.—For Licentiates of College; Primary examination, £15 15s.; Final examination, £10 10s. Licentiates in Surgery of other licensing bodies: Primary examination, £26 5s.; Final examination, £15 15s. Students of the College: Primary examination, £5 5s.; Final examination, £21. Students of other licensing bodies: Primary examination, £10 10s.; Final examination, £31 10s.

Grade 2.—Licentiates of the College, £26 5s.; Licentiates in Surgery of other licensing bodies, £42.

APOTHECARIES' HALL OF IRELAND.

The Licence of this Hall is granted to students who present certificates of having fully completed the course of study as laid down in the curriculum, and who pass the necessary examinations. The diploma of the Apothecaries' Hall of Ireland entitles the holder to be registered as a practitioner in medicine, surgery, and midwifery, and he also possesses the privileges of an apothecary.

There are four professional examinations, the total fees for which amount to 21 guineas. Women are eligible for the diploma.

Registered Medical Practitioners will receive the diploma of the Hall upon passing an examination in the subject or subjects not covered by their previous qualification, and on paying a fee of ten guineas; if medicine or surgery is required, five guineas extra will be charged.

The fees payable for each examination are as follows: First Professional, £5 5s.; Second, £5 5s.; Third, £5 5s.; Final Examination, £6 6s.

A candidate is allowed for each professional examination which he has completed at any other licensing body, except the Final. If he has passed only in some of the subjects in a given examination, he has to pay the whole of the fee for that examination.

The fees for re-examination are: For each subject, £1 1s., excepting in the subjects of chemistry, pharmacy, surgery, medicine, second anatomy, physiology, pathology, and ophthalmology, the fees for which are £2 2s. each.

The fee for the Third and Final, or Final alone, is £15 15s., when the other examinations have been taken elsewhere.

All examination fees are to be lodged in the Sackville Street Branch of the Royal Bank of Ireland to the credit of the Examination Committee.

Applications and schedules, together with bank receipt for the fee, must be lodged with the Registrar, Apothecaries' Hall, 40 Mary Street, Dublin, at least fourteen clear days before the day of examination.

Candidates who desire to obtain the Letters Testimonial of the Apothecaries' Hall of Ireland, must, before proceeding to the Final Examination, produce evidence of having been registered as medical students for fifty-seven months; also of having attended courses of instruction as follows

One course each (winter course of six months) of the following: Anatomy (lectures), chemistry (theoretical), midwifery, practice of medicine, physiology and surgery. Dissections, two courses of six months each.

Courses of three months.—Materia medica, medical jurisprudence, chemistry (practical), practical physiology and histology, operative surgery, physics, clinical ophthalmology, biology, clinical instruction in mental disease, pathology, and a course in vaccination.

Medico-Chirurgical Hospital, twenty-seven months to be distributed over the last four years of study. The candidate may substitute for nine months in this, hospital attendance six months as a resident pupil.

Three months' study of fever.

Six months' practical midwifery and diseases of women.

Three months' practical pharmacy in a recognised clinical hospital or a recognized school of pharmacy, or a year in the compounding department of a licentiate apothecary or a pharmaceutical chemist.

Each candidate before receiving his diploma must produce evidence that he has attained the age of 21.

Each candidate must produce evidence of having before entering on medical studies passed a preliminary examination in general education recognised by the General Medical Council, and of having been registered by that Council as a student in medicine. Certificates of medical study will not be recognised if the commencement of the course to which the certificate refers dates more than fifteen days prior to such registration, except in the subjects of physics and biology. This registration is not undertaken by the Hall.

The details of the course of education required and syllabus of the examinations will be supplied on application to the Registrar, at 40 Mary Street, Dublin.

LICENCE IN DENTAL SURGERY.

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 University of Dublin grants both a Degree and a Licence in dental surgery. To obtain the former, candidates must have taken a degree in arts; the licence is obtainable by all duly qualified persons who have passed the Public Entrance Examination of Trinity College, Dublin. The Royal College of Surgeons in Ireland grants a Licence in Dentistry.

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.

All information concerning this licence may be obtained from the Registrar of the College. The Primary Dental Examinations commence on the second Monday in the months of February, May, and November. The subjects of examinations include physics, chemistry (including metallurgy), anatomy, physiology and histology, and surgery. The fees for the primary Dental Examination amount to £10 10s; and for re-examination, if rejected, £5 5s. The Final Dental Examinations commence on the Thursdays immediately following the Primary Dental Examinations. Candidates are examined in dental surgery, theoretical (including dental pathology), clinical, and operative; and in dental mechanics, theoretical, clinical, and practical (including the metallurgy of the workshop). Candidates must pass in all the subjects at the same time.

The fees for the Final Dental Examination in the case of candidates holding the L.R.C.S.I., or students who have passed the Primary Dental or Third Professional Examination of the College, £10 10s.; re-examination, £5 5s. The fees for Final Examination of all other candidates, £26 5s., and for re-examination, £10 10s. The extra fee for Special Examination, £5 5s. A rejected candidate will not be again admitted to examination until after a period of three months.

THE DIPLOMA IN PUBLIC HEALTH.

This diploma is granted by Dublin University, the Royal University, and the conjoint 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 addition to taking the prescribed course a candidate for the D.P.H. of the University of Dublin must be a Doctor in Medicine or a graduate in Medicine, Surgery, and Midwifery of Dublin, Oxford, or Cambridge, and his name must have been on the "Medical Register" for at least twelve months before the examination. The Royal University only confers its diploma on its own graduates.

THE DIPLOMA IN PSYCHOLOGICAL MEDICINE.

The Royal University of Ireland grants a diploma for proficiency in the treatment of mental diseases under the following conditions:—

The diploma is conferred only on graduates in medicine of the University. Candidates must give notice, in writing, to the secretaries of their intention to present themselves, and must pay the prescribed fee of £2 at least one month previous to the examination. Candidates who satisfy the examiners will be required to pay a further fee of £3 before the diploma is conferred. The subjects for this examination are those required by the Hutchinson Stewart Scholarship for proficiency in the treatment of mental diseases.

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.

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 examinations of the University, 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 Final 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 Intermediate Medical Examination, Part I., in Anatomy and Institutes of Medicine, shall obtain highest marks in Physiology and Histology, provided that he passes the examination in full.

Fitz-Patrick Scholarship.—This scholarship consists of the interest on £1,000. It will be awarded annually to the student who obtains the highest aggregate marks at the five sections of the Final Examinations, provided that he has completed his medical course in the prescribed period of five years.

THE ROYAL COLLEGE OF SURGEONS IN IRELAND. SCHOOLS OF SURGERY.—These schools are attached by Charter to the Royal College of Surgeons, and have existed as a department of the College for over a century. They are carried on within the College buildings, 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 pathological, bacteriological, public health, chemical, and pharmaceutical laboratories fitted with the most approved appliances, in order that students may have the advantage of the most modern methods of instruction. A refreshment room is now open, where students can have luncheon. There are special rooms set apart for lady students. The entire building is heated by hot-water pipes, and lighted throughout by the electric light.

All the lectures and courses of practical instruction may be attended by medical students who are otherwise unconnected with the College.

All the diplomas 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, £31 10s.; the Carmichael Scholarship, £15; the Mayne Scholarship, £8. The Gold and Silver Medals in Surgery and the Stoney Memorial Gold Medal in Anatomy.

Class Prizes of £2 and £1, accompanied by medals if sufficient merit is shown, will also be given in each subject. Prospectus and Student's Guide can be obtained on written application to the Registrar, Royal College of Surgeons, Dublin.

Two short post graduate courses are held in the year. Full particulars can be obtained from the Registrar.

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 total fees for school and hospital courses is £160, payable as the courses are taken out.

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 Conjoint Colleges Exhibition 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 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 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 scholarship examinations are held in October.

QUEEN'S COLLEGE, BELFAST.

The total cost of the medical curriculum of the Royal University of Ireland, including examination fees and perpetual fee for the Royal Hospital, but not including fees for the special hospitals, is about £95. If the Conjoint Examination of the Royal Colleges is taken the expense is almost the same.

Clinical instruction is given at the Royal Victoria Hospital. The Union Hospital, the Maternity Hospital, the Ulster Hospital for Women and Children, the Hospital for Sick Children, the Ophthalmic Hospital, the Ulster Eye, Ear, and Throat Hospital, and the District Lunatic Asylum are also open to students.

Prizes.—(1) Ten medical scholarships each year, value £20 each; (2) two Dunville studentships (one each year), value £150 each; (3) one Andrews student ship each alternate year, value £140; (4) numerous sessional prizes.

During the summer session special classes are formed in bacteriology and clinical pathology, and during the winter facilities are afforded to medical men to work at these subjects in the pathological laboratories. From time to time lectures and demonstrations are given in the anatomical department on the Advanced Anatomy of the Nervous System, or some other department of applied anatomy.

A pamphlet containing full information can be had on application to the Registrar, Queen's College, Belfast.

QUEEN'S COLLEGE, CORK.

The arrangements in the Faculty of Medicine are made chiefly with reference to the requirements of the Royal University of Ireland, but students proceeding for the examinations of the Conjoint Boards of England, Scotland, or Ireland, the Society of Apothecaries of London, or the Apothecaries Hall of Ireland, can arrange the course of lectures which they attend, and the order in which they attend them, to meet the requirements of those bodies. Certificates of attendance in the college are also accepted by the University of Cambridge. The total fees for the college lectures and Hospital attendances required by the Royal University of Ireland is about £85.

Clinical instruction is given at the North and South Infirmaries. Students can also attend the Mercy Hospital, the Cork Union Hospital, the County and City of Cork Lying-in Hospital, the Maternity, the Hospital for Diseases of Women and Children, the Fever Hospital, the Ophthalmic and Aural Hospital, and the Eglinton Lunatic Asylum. The winter session commences on October 27th, and ends at the end of April. The courses of the summer session are delivered in the months of April, May, and June.

Scholarships and Prizes.—Eight medical scholarships, two in each of the first four years, of the value of £25 each, and in the fifth year the Blaney Scholarship of the value of about £32, and a Senior Exhibition, value £30. Three Exhibitions, one in practical medicine, one in practical surgery, and one in practical midwifery, each

of the value of £15. Book prizes at the sessional examinations.

Further information can be obtained in the College Regulations, or on application to the Registrar, Queen's College, Cork.

QUEEN'S COLLEGE, GALWAY.

Clinical teaching is carried on in the Galway Hospital, established as a Public General Hospital (in the place of the County Galway Infirmary) by Act of Parliament (1892). The Galway Fever Hospital is also open to students. The medical lectures are recognised by the Royal University of Ireland and the various Licensing Bodies in the United Kingdom.

Prizes.—There are eight Junior Scholarships in Medicine of the annual value of £25 each. Two are tenable by matriculated students of the first, second, third, and fourth years. The Council has power to award exhibitions for distinguished answering. Sessional prizes are offered in each subject. A Senior Scholarship in Anatomy, value £40, the holder of which is usually appointed Demonstrator, is offered annually for competition, tenable for one year by a student who shall have attended the Medical School of the College for at least two sessions, and shall have obtained a Degree in Arts or Medicine, or a Diploma in Medicine, from a Licensing Body. Scholarship examinations are held at the commencement, and those for Sessional Prizes at the close, of each session.

THE PHARMACEUTICAL SOCIETY OF IRELAND.

The Pharmaceutical Society of Ireland issue two qualifications and a certificate. The qualification of Registered Druggist; the qualification of Pharmaceutical Chemist; and the certificate of competency as Assistant to a Pharmaceutical Chemist.

Registered Druggist.—This qualification entitles the holder to keep open shop for the selling, retailing, and mixing of poisons. In order to obtain it, a person must now have served an apprenticeship or assistantship of four years to an apothecary, pharmaceutical chemist, or to a person who was, or would have been entitled to become, a registered chemist and druggist or a registered druggist, and be 21 years of age. He shall be examined with respect to his knowledge of English orthography and composition, arithmetic, and the weights and measures of the British Pharmacopœia, the appearance and properties of the various drugs and chemicals in general use, and as to the provisions of the Poisons Act. The fee is four guineas.

Examinations in Dublin (also in Belfast and Cork or other place if 12 candidates offer) on the second Tuesday of January, April, July, and October.

Pharmaceutical Chemist.—The qualification of a pharmaceutical chemist in Ireland confers greater privileges than is the case in England.

The subjects of examination are divided between the "Preliminary" and the "Licence."

The Preliminary examination is held on the first Thursday and following day of January, April, July, and October.

The fee is £2 2s. for the first attempt, and 10s. 6d. for each subsequent examination. Further particulars with reference to the subjects for examination may be obtained from the Registrar. The British Society's examination is accepted in lieu of this, as well as those recognised by the General Medical Council as a preliminary to medical studies.

Pharmaceutical Licence Examination.—This examination confers the title of Pharmaceutical Chemist and the right to compound medical prescriptions. Candidates must be 21 years of age, and must have passed the Preliminary prior to the service at practical pharmacy, unless such service was commenced before 1st January, 1907. They must, unless having passed the Preliminary previous to 1884, produce certificates of having served four years as assistant or apprentice to an apothecary or pharmaceutical chemist or four years to a druggist, two years to an apothecary or pharmaceutical chemist, also a certificate of having attended a course of practical chemistry of not less than three months' duration and of having actually worked at the bench for 100 hours during the said course at a recognised school; and also a course of botany and materia medica. The fee for examination is five guineas, and for re-examination two guineas. Examinations are held in Dublin on the second Wednesday and following day of January, April, July, and October.

Assistant to a Pharmaceutical Chemist.—The examination for the certificate of competency as an assistant may be described, in brief, as the same as that for the Licence, minus the examination in chemistry and botany, with the fee reduced to one guinea (half a guinea on the second and subsequent attempts). The Preliminary examination must be passed as for the Licence, and the usual 14 days' notice must be given. Candidates must have been engaged in practical pharmacy for four years.

Examinations are held on the Monday following the pharmaceutical Licence examination or on such days as the Council may direct.

DEPARTMENT OF AGRICULTURE AND TECHNICAL INSTRUCTION FOR IRELAND.

ROYAL COLLEGE OF SCIENCE FOR IRELAND.

SESSION 1906—1907.

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 agriculture, 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 several entrance scholarships, (*a*) in agriculture, and (*b*) in science and technology, tenable for three years, of the value of £50 each yearly, with free tuition. 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 first year associate students at the end of each session. All the laboratories and drawing schools are open daily for practical instruction. The Session commences on Tuesday, October 2nd.

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, botanical, and geological laboratories.

The Entrance and Science Scholarship Examinations are held about the first week in July, and the Examinations for Agricultural Scholarships in the second week in September.

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 orthopædic 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, with the five years of study. The fee at all general hospitals is £8 8s. in winter, and for the summer £6 6s., or £12 12s. for the entire session of nine months if taken together.

GENERAL HOSPITALS.

RICHMOND, WHITWORTH, AND HARDWICKE HOSPITALS.—The accommodation at these hospitals is as

follows:—Hardwicke Hospital, 120 beds; Whitworth Hospital, 64 beds; Richmond Hospital, 86 beds—total, 270 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. Instruction is also given on various special 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 large ophthalmic, aural, throat, and gynæcological dispensaries, and instruction in these important subjects is given. Eight resident clinical clerks are appointed each quarter, and provided with furnished apartments, fuel, &c. The appointments are open not only to advanced students, but also to those who are qualified in medicine and surgery. A house surgeon for the Richmond Hospital and a house physician for the Whitworth and Hardwicke Hospitals are elected every six months, and receive a salary. The Richmond Lunatic Asylum, containing 1,600 beds, adjoins 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, containing 40 beds, 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 three 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, Mr. William Taylor, F.R.C.S., 47, Fitzwilliam Square, Dublin.

THE ADELAIDE MEDICAL AND SURGICAL HOSPITALS 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. Two House Surgeons are elected annually and three resident pupils half-yearly. 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 Mr. Heuston, F.R.C.S.I., 15, St. Stephen's Green North.

THE ROYAL CITY OF DUBLIN HOSPITAL.—This hospital has recently 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 anæsthetic room have been constructed in accordance with the most modern surgical requirements. A Röntgen-ray and light treatment of lupus department has recently been added. 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. Special classes for first year students. Full particulars can be had on application to Mr. G. Jameson Johnston, M.B., F.R.C.S.I., Hon. Sec. Med. Board.

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 almost 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. There is a special wing devoted to fever cases, and regular clinical instruction is given by the members of the medical staff throughout the winter and summer sessions. Special classes for students commencing their hospital studies will be held in these departments during the months of October, November, and December. They will embrace the elements of medicine and surgery, including note-taking. Opportunities are also afforded to students for examining cases of throat, ear, and eye diseases, as well as for performing minor surgical operations and bandaging. In the X-ray Department opportunities are given the members of the hospital class of seeing the various applications of the X-rays to the diagnosis and treatment of injury and disease.

MATER MISERICORDIÆ HOSPITAL.—This hospital, containing 335 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 gynæcology 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. 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.

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 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. 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 Mr. R. Charles B. Maunsell, M.B., F.R.C.S., 32 Lower Baggot Street, Dublin.

ST. VINCENT'S HOSPITAL was established in 1834, it 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. 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. Dargan, 45, Stephen's Green, East Dublin.

DR. STEEVENS' 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 a new and thoroughly equipped dispensary and out-patient department has been completed and opened to patients. There is accommodation for twelve resident pupils—four medical, six surgical, and two in the special departments, each of whom is supplied with a separate room. All information with regard to these appointments can be had from the Resident Medical Officer at the hospital. 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 is the oldest established in Dublin. The new hospital was completed in 1896, since which time it has been open for the reception of patients. In addition to 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.

Students of Jervis Street Hospital are entitled to attend free of charge the Children's Hospital, Temple Street, which contains 100 beds, and where special lectures are given on Diseases of Infancy and Childhood, and on Orthopædic Surgery and appliances, and to obtain special courses in fevers at Cork Street Fever Hospital.

SPECIAL HOSPITALS.

The special hospitals of Dublin are the Rotunda, the Coombe, and the 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 Orthopædic Hospital, the Children's Hospitals in Harcourt Street and in Temple Street, and the City Hospital for Diseases of the Skin.

THE ROTUNDA HOSPITAL.—This institution is the largest, the longest established, and the most famous gynæcological as well as maternity hospital in the British Empire. The work performed by it is about three times greater than that of any other hospital of its kind in Ireland. The number of patients admitted to the hospital, and also attended in the extern maternity has increased enormously within recent years. The routine daily work comprises the attendance of lectures on midwifery and gynæcology; practice in abdominal palpation; personal conduction of parturition both in the extern and the intern maternities; cystoscopic examinations, as well as attendance at the operation work of the hospital. The hospital affords exceptional advantages to qualified men who take out a three months' course during the autumn, winter, and spring months, for they (if considered competent) are permitted a certain amount of practical operation work, viz.—forceps, curettings, perineorrhaphy, &c. Students are liable to summary dismissal without refund of fees for gross misconduct, or serious breach of the hospital rules. A special afternoon class in gynæcology is held by the Senior Assistant, £2 2s. per month. The Pathological laboratory under the direction of Dr. Rowlette has become an important feature of the hospital. Students can enter at any time for periods of one month or longer. Certificates of attendance are accepted by all the licensing bodies. The L.M. certificate is obtained by attendance at the hospital for six months, with the subsequent passing of an examination. A special certificate in gynæcology is presented to students whose work meets with the Master's approval. Paid clinical assistants are selected (from among those who have obtained the hospital L.M. certificate) by competitive examination, for periods of six months. The residents' quarters have undergone complete renovation and now afford comfortable accommodation. The grounds of the hospital contain asphalt and grass courts for lawn tennis and croquet. There is also a full-size billiard table.

Fees for Pupils.—Intern:—One month, £6 6s.; two months, £9 9s.; three months, £12 12s.; six months, £21; single months other than the first, £4 4s; board and lodging in the house per week, £1 5s. Night students (not resident in house), £6 6s. for first three months; £4 4s. for the second three months. For further particulars apply to E. Hastings Tweedy, Master, Rotunda Hospital, Dublin.

COOMBE LYING-IN HOSPITAL.—This hospital consists of two divisions, one of which is devoted to lying-in cases, and the other to the treatment of diseases peculiar to women. The practice of this hospital is one of the largest in Ireland; nearly 18,000 cases are treated annually, either as intern or extern patients. Lectures are delivered, practical instruction is given, and gynæcological operations are performed in the theatres daily. There is a general dispensary held daily, at which instruction is given on the diseases of women and children. There is a special afternoon dispensary held by the Master and his assistants, at which practical instruction in gynæcology is given. This is the largest dispensary of its kind in Dublin. There is no extra charge for attendance at this dispensary. There is accommodation for a number of qualified and unqualified intern pupils, who enjoy exceptional advantages of acquiring a thorough knowledge of this branch of their profession. Lady medical students can reside in the hospital. Clinical assistants are appointed from among the pupils as vacancies occur. Certificates of attendance at this hospital are accepted by all licensing bodies, and the diploma is recognised by the Local Government Board as a full legal midwifery qualification. The residents' quarters have been much enlarged. A billiard table has been erected for the use of students. Extern pupils pay, for full course of six months, £8 8s. Intern pupils pay one month, £4 4s., six months, £18 18s. Board and lodging in the hospital, 18s. per week. Lady students' intern pay for one month, £5 5s.; each consecutive month, £4 4s.

* NATIONAL MATERNITY HOSPITAL.—This institution, under the mastership of Dr. Barry and Dr. A. 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. The department is at present in process of being reorganised.

CORK STREET FEVER HOSPITAL is the only special fever hospital in Dublin. It is supported mainly by subscriptions, 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. There are also courses for the Diploma in Public Health. All particulars may be obtained on application to the Medical Superintendent.

THE NATIONAL CHILDREN'S HOSPITAL for the treatment of all non-infectious diseases peculiar to children, 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 Sir Lambert H. Ormsby, F.R.C.S.I.

*THE CHILDREN'S HOSPITAL, DUBLIN (under the care of the Sisters of Charity).—This institution is one of the most progressive and up-to-date children's hospitals in the Kingdom, besides being the largest in Ireland. There are 100 beds available for patients; about 1,000 cases are admitted to the wards annually; and about 7,000 or 8,000 seen in the dispensary. During the last year a new operating theatre has been opened. It is fitted and furnished in the best possible fashion for present-day surgery. Special attention is given to orthopædic surgery, and the number of deformities from all parts of Ireland treated and cured in the hospital is rapidly increasing. A special masseuse has been appointed to the hospital to aid in this department.

The hospital is recognised for clinical instruction in the diseases of children by the R.U.I. and licensing bodies, which require a certificate of instruction in this important branch of medical education. A nursing home is in connection with the institution, and trained nurses are always available for private cases. Senior students or others requiring a post-graduate course at the hospital should apply for full particulars to M. C. Staunton, hon. sec., or to any member of the staff.

THE INCORPORATED ORTHOPÆDIC HOSPITAL, IRELAND.—This hospital was founded in 1876, and contains 80 beds. It is available for every class of deformity available for treatment. Particulars may be obtained from Captain Borthistle, Registrar, at the hospital, or from R. L. Swan, F.R.C.S.I., 32 Stephen's Green.

THE ROYAL VICTORIA EYE AND EAR HOSPITAL, Adelaide Road, Dublin.—This hospital, which was opened in March, 1904, is an amalgamation of St. Mark's Ophthalmic Hospital and the National Eye and Ear Infirmary. The hospital contains 80 beds. Clinical instruction in diseases of the eye and ear, including the use of the ophthalmoscope and operations, is given daily from 10 till 1. Special classes for practical instruction in the use of ophthalmoscope, &c., and for the demonstration of cases, are formed from time to time.

THE INCORPORATED DENTAL HOSPITAL, Lincoln Place.—This 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 *clientèle* and extensive practice among the Dublin poor. The fees are £15 15s. for the first year's study, and £12 12s. for second, and proportionately smaller fees for shorter periods.

THE CITY HOSPITAL FOR DISEASES OF THE SKIN AND CANCER, Great Brunswick Street.—The first and only one of its kind in the city was the first in Ireland to instal the Finsen treatment. Senior students are admitted free to the practice of this hospital, which has a large daily out-patient attendance, with 15 beds available for the admission of acute cases. Classes of instruction will be given at regular intervals during the winter and summer sessions in the use of the Finsen light, X-rays, high frequency currents and radium, with demonstrations on (1) the production and use of the Röntgen rays, (2) electric currents, direct and alternating, with description of resistances, rectifiers and transformers; (3) accumulators, their construction, use, and methods in charging; (4) vacuum tube, choice of tube for particular kinds of work. Fluorescent screen, and how to localise foreign bodies.

BELFAST HOSPITALS.

*HOSPITAL FOR SICK CHILDREN, Queen Street.—This institution, erected by voluntary donations, and supported by voluntary contributions, was opened for the reception of patients on April 24th, 1879. The hospital consists of a medical ward with twenty-eight beds, and one of a similar size for surgical cases. It is strictly non-sectarian in its principles, and is open to all denominations. Children from birth to the age of 12 years, and not suffering from contagious disease, are admissible as in-patients. A very large extern is conducted in the out-patient department between the hours of 9 and 10 a.m., where children from birth to 14 years are attended to. The convalescent home, which is situated at Newtownbreda, contains thirteen cots, and its situation and equipment render it an admirable adjunct to the after-treatment of the cases admitted to the hospital. During the winter session systematic courses of lectures and demonstrations in the medical and surgical diseases of infancy and childhood are delivered in the wards on Wednesday and Friday of each week at 9 a.m.

* MATER INFIRMORUM HOSPITAL.—Established 1883. 160 beds. The New Mater Hospital, which was erected at a cost of over £50,000, was formally opened on April 23rd, 1900. During the year the intern patients numbered 1,525; accidents, 3,762, and cases treated in the Dispensary, 22,597; 389 surgical operations were performed with the most satisfactory results. The total number of patients who received treatment was 27,884, being an increase of 1,517 as compared with the year 1904. A notable feature is in the number of accident cases, as the hospital is conveniently situated in proximity to a large working-class population, and within easy reach of most of the public works.

THE BELFAST MATERNITY HOSPITAL (INCORPORATED).—Established 1794. 25 beds.—The practice of the Maternity Hospital, the certificate of which is recognised by the Royal University, &c., &c., is open to students. The fee for the session is £2 2s. Resident nurses are also received for training for a period of six months, and a diploma given which is recognised by public bodies. Conditions for such on application to the Matron. During the year 1905, 326 patients were treated in the hospital, and 312 patients at their own homes. Besides this, 186 patients were dealt with in the extern gynæcological department. Clinical lectures and bedside demonstrations are given by members of the staff during both the winter and summer sessions. Students wishing to attend should apply to Dr. H. D. Osborne, 32 Lonsdale Terrace, Belfast, Hon. Secretary to Medical Staff, on or before November 1st and May 1st.

Note.—Hospital was rebuilt in 1904 and removed to splendidly equipped new premises in Townsend Street. A Resident Surgeon elected periodically.

OPHTHALMIC INSTITUTION AND EYE AND EAR HOSPITAL, Great Victoria Street, Belfast.—Established 1844. New hospital erected, 1867. New extern department and operation theatre added, 1902. This hospital is situated on the main road between Queen's College and the Royal Victoria Hospital. It contains about 30 beds for intern patients, and a large extern department. The latter is open on Monday, Wednesday and Friday at noon for eye cases, and on Monday and Thursday at noon for ear and throat cases. Special courses of instruction are given during the winter and summer sessions, but students can enter at any time, and can always obtain plenty of practice in ophthalmoscopic work. Full particulars may be had from Dr. Cecil Shaw, 18 College Square East, Belfast.

ROYAL VICTORIA HOSPITAL.—Established 1791; incorporated by Royal Charter, 1875 and 1898. New hospital opened, September 17th, 1903. 300 beds; Convalescent hospital, 24 beds; Children's Hospital, 33 beds; Consumptive Hospital, 10 beds.

ULSTER EYE, EAR, AND THROAT HOSPITAL.—Established 1871. New hospital opened 1874. 30 beds.

ULSTER HOSPITAL FOR CHILDREN AND WOMEN, Mountpottinger, Belfast, is the only hospital in the large part of the city situated on the County Down side of the river. It is placed in a working class district, and has a great field for its charitable operations. There are in the hospital about twenty-two beds for children and eight for women. There is an

extern department for children open every week-day, except Saturday, from 9 till 10, and for women at 11.30, and a special department for diseases of the eye, ear, and throat on Tuesdays and Fridays from 9 till 10. During the summer and winter sessions, clinical instruction is given to students daily, operations being chiefly performed on Wednesday and Saturday. There is a resident midwife for extern work, and every facility is afforded students for attending their cases in the district.

CORK HOSPITALS.

VICTORIA HOSPITAL FOR WOMEN AND CHILDREN.—Established 1874. 70 beds. An immense amount of work is done in this hospital to relieve the poor of Cork, Kerry, and other counties. This year a fine new anæsthetic room has been added to the already perfect theatre, where a large number of successful operations are done every year. The hospital contains several very fine private rooms for paying patients.

* COUNTY AND CITY OF CORK LYING-IN HOSPITAL.—Established 1798. 17 beds.

* EYE, EAR, AND THROAT HOSPITAL, Western Road.—Incorporated 1898. 35 beds. Inpatients treated during year, 454; outpatients, 4,238. Clinical Instruction is given during college session. Special demonstrations in the use of the ophthalmoscope, larynogscope, &c., are given from time to time.

* FEVER HOSPITAL AND HOUSE OF RECOVERY.—Established 1801. 110 beds.

* MATERNITY.—Established 1872.

* MERCY HOSPITAL.—Established 1857. 80 beds.

* NORTH CHARITABLE INFIRMARY.—Established 1774. 110 beds. Spec al wards for treatment of diseases of women and children. The extern department is largely availed of, and the number of accidents treated is very large. Clinical instruction is given daily from 9.30 a.m. to 12 noon. A new and thoroughly up-to-date operating theatre has recently been added at enormous expense.

CORK SOUTH INFIRMARY AND COUNTY HOSPITAL.—Founded 1773. The hospital contains 100 beds, available for clinical instruction, 40 medical and 60 surgical. There are also special wards devoted to the treatment of diseases peculiar to women and children, and a large medical and surgical extern department.

Clinical instruction is given daily during the session from 9.30 to 11.30, in both the medical and surgical wards, and clinical lectures are regularly delivered.

The operation and sterilising rooms are thoroughly up to date. The X-ray department is fully equipped with the newest apparatus necessary for such work. Students are regularly instructed in the methods of using the rays by practical demonstration on the cases requiring their use.

The hospital has been largely availed of by students of the Cork School of Medicine.

GALWAY HOSPITALS.

* COUNTY HOSPITAL.—Established 1786. 60 beds.

* No answer to our request for information received from these hospitals.

IRISH PUBLIC SERVICES.

THE POOR-LAW MEDICAL SERVICE.

For several years past the unsatisfactory nature of the Irish Poor-law Medical Service, as a career for young practitioners, has furnished a theme for the opening addresses at all the leading medical schools. In addition to the petty annoyances, the laborious and harassing duties, and the ever-increasing amount of clerical work which the new orders of the Local Government Board impose from time to time, the unfortunate medical officers are grievously underpaid, their salaries being totally out of proportion to the duties discharged, and in the majority of rural districts barely sufficent to cover the out-of-pocket expenses, such as are incurred in the keep of a horse and man, and other servants. The Local Government Board have recently laid it down, moreover, that the dispensary patients have the first call on the time of the medical officer, and that, even if he is engaged on an urgent private case, he must give it up and go off to attend on a scarlet-runner, as the dispensary visiting tickets are not inappropriately called. So strictly is he bound up to the discharge of his duties that unless incapacitated by sickness or other cause, or with the permission of the guardians expressly granted, he cannot leave his district for a single day, even if he makes provision for the performance of his duties in his absence by a brother practitioner. 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, almost the same 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. (4) That there is no compulsory superannuation, and, as a consequence, many old and infirm doctors are forced to remain on in the Service long after they have become unfit to discharge the duties, seeing nothing but extreme poverty and perhaps the workhouse itself staring them in the face.

We need go no further than to say that the Irish Poor-law Medical Ser vice is a service to avoid. We therefore strongly urge on young medical men the importance of supporting the interest of the profession by refraining from applying for vacant posts of which the salary is nsufficient, from accepting posts as *locum tenens* at a lower rate than £4 4s. per week.

There are 159 workhouses and about 810 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.

Qualifications.—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.

Duties.—The duty of the dispensary doctor is twofold. He has 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 guardian, warden, 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 many districts he has to make up all the medicines for the poor.

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 medical

officer. 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 long journeys across the country are involved.

THE IRISH LUNACY SERVICE.

This service, at present, affords a comfortable livelihood 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 must devote their whole time to their duties.

Heretofore the appointments of Medical Superintendents have been in the patronage of the Lord Lieutenant, but, under the Local Government Act, they are 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 is appointed by the Committee of the County Council to which the management of the 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.

OTHER APPOINTMENTS.

There are, in addition to those which we have mentioned, certain appointments open to medical practitioners in special localities. They are :—

(1) Attendance on the Royal Irish Constabulary. (2) Attendance on the Coastguards. (3) Factory Surgeoncies. (4) Attendance upon the depôt 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 5s. to 2s. 6d. per visit. The appointments rest with the Admiralty, but are usually secured for the local Poor-law Medical Officer. The emoluments depend on the number of stations and men.

Factory surgeoncies are in the gift of the Chief Inspector of Factories in Whitehall. 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 depôts is not worth mentioning.

Scotland.

NOTWITHSTANDING the increased competition which the recent vigorous growth of the great English provincial medical schools, added to the unsurpassed attractions of the historic Metropolitan hospitals, with their staffs of renowned teachers, ensures, the Scottish medical schools seem fully to retain their popularity, not only, as is natural, among Scotsmen and their colonial descendants, but among medical students from England, Wales, and Ireland, and, indeed, all parts of our Empire. In fact, if appearances be any guide, it would seem that the number of Oriental students attending classes in Edinburgh is increasing year by year. And undoubtedly the competition of other centres has had the advantage of making Scottish teachers bestir themselves, with the result that the efficiency of the medical schools is now much greater than a decade ago. The advantages derived from the second half of the Carnegie Bequest, *i.e.*, the improved equipment of the teaching schools and the encouragement of post graduate research are now manifesting themselves, and will prove permanent factors in promoting the well-being of the Universities and Scottish education generally. Of the four universities, Edinburgh, of course, occupies the premier position as a medical school, but at Glasgow, Aberdeen, and St. Andrews, an almost equally good—indeed, in individual details, better—training can be obtained. Two ordinary qualifications to practise are granted in Scotland—the M.B., Ch.B. of the Universities, and the triple qualification of the Colleges of Physicians and Surgeons of Edinburgh and the Faculty of Physicians and Surgeons of Glasgow. The examinations for the University degree naturally are more exacting than those for the triple qualification, and the curriculum wider. Nevertheless, the standard for the latter is being steadily raised, though on account of the large number of examiners in most subjects it is probably slightly less uniform than that of the universities, where the examinations are conducted by the professors with one or more extra-mural assessors in each subject. Two features of the Scottish system deserve mention—first, as regards the co-ordination of various separate teaching bodies in each centre ; second, as regards the conditions under which the students live, Around each university there has grown up an extra-mural medical school, in which the teachers are hospital physicians, surgeons, and specialists unconnected with the university, but whose classes qualify for graduation. Thus the student has usually ample choice, and can, within certain limits, attend the teacher from whom he thinks he will derive most benefit, while the extra-mural lecturers, being unendowed and constantly recruited by fresh blood, have a permanent incentive to keep their courses up to the mark, since any slackness is at once followed by a diminution in the number of students' fees. In hospital work it is the same, the student having the option of attending a clinical professor and an ordinary physician or surgeon. A very important part of the student's clinical work, too, is done at institutions and under teachers quite unconnected with the universities ; this is his dispensary practice, which may be taken at one of several dispensaries situated in the poorer districts of the towns. Until recently, practical training in obstetrics was one of the least satisfactory parts of the teaching in Edinburgh, and many students were in the habit of going to Glasgow or Dublin for their maternity work. Recently, however, steps have been taken which should render this unnecessary, and ought to give Edinburgh students quite sufficient opportunity of acquiring as good a practical acquaintance with this most important subject as they have of obtaining a theoretical knowledge of it. From what has been said it will be seen that university undergraduates and triple qualification men rub shoulders at every turn—in the wards, dispensary, and lecture-room. University students have the privilege of studying

under both intra- and extra-mural teachers, while men going up for the triple qualification are limited to the latter. It is not uncommon, therefore, for a man to come up intending to take the licence, and to change his mind and go in for a degree, or *vice versâ*, and this can usually be done without much added expense or taking out many fresh classes, provided the change is not made too late in the curriculum. The weak spot in the Edinburgh curriculum is the overcrowding of subjects in certain years. The most feasible means of remedying this would seem to be a division of the *annus medicus* into three instead of two sessions, a scheme which has received a certain amount of support, but is as yet far from becoming *un fait accompli*.

For the rest, the student lives as he likes and where he likes; the authorities only demand that he shall attend classes with due regularity and diligence, and exhibit sufficient proficiency to pass his examinations. Most men live in lodgings, a few board with private families, and some live in the various halls of residence which have been established. In these last, too, the student is his own master, the halls being managed solely by a committee of the residents for the time being. It is impossible to make any very definite statement as to the relative cost of a medical education in the different schools, as compared with London and Dublin, as so much depends on the extra classes taken out, the mode of living, and so on. The minimum inclusive fees for the licence are £120, for the M.B. degree about £145; but almost every student finds it practically necessary to attend additional classes. On the whole, the cost of living is highest in Edinburgh, lowest in Aberdeen; in the former, while the rent of lodgings is lower than in London, maintenance, including clothing and provisions, is somewhat more expensive. Incidental expenses, amusements, &c., are, however, considerably less in the Northern capital. In Aberdeen, money goes much further than in the south, and the student ought to keep himself on about two-thirds of the funds required in Edinburgh.

THE CARNEGIE TRUST.

Through the munificence of Mr. Andrew Carnegie, LL.D., payment is now made "of the whole or part of the ordinary class fees exigible by the Universities from students of Scottish birth or extraction, and of sixteen years of age or upwards, or scholars who have given two years' attendance, after the age of fourteen years, at State-aided schools in Scotland, or at such other schools and institutions in Scotland as are under the inspection of the Scottish Education Department."

The Trust provides for the payment of the class fees of the above students proceeding to graduation in medicine or science. Application for payment of class fees under the conditions of the Trust should be made to the Secretary, Mr. W. S. McCormick, Merchants' Hall, Hanover Street, Edinburgh.

Scholarships, Fellowships, and Grants in aid of original research are now awarded annually by the Trust. For particulars, conditions, &c., apply to the Secretary.

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. A degree in Arts or Science of a British or other recognised 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, aritbmetic, and the elements of mathematics, and Greek, or 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 courses, 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 botany, zoology, physics, practical chemistry, practical physiology, practical pathology, and medical jurisprudence during courses of not less than 2½ months each; public health, not less than forty lectures; practical anatomy, during two courses of not less than five months each; chemistry, anatomy, physiology, pathology, surgery, materia medica, medicine and midwifery during courses of not less than five months each. Eight of these subjects must be taken at a University or college affiliated to a University entitled to grant the degree of M.D. He must attend a course of twenty-five lectures 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, and attended for six months the practice of a dispensary, or of a physician and surgeon. He must also have had approved opportunities of studying (1) operative surgery; (2) mental diseases at a recognised asylum; (3) at a recognised hospital, *post-mortems*, fevers, and diseases of the eye; and (4) one of the following: Diseases of children, of the ear, nose and throat, or of the skin; (5) vaccination.

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 on or before the date for lodging certificates for the final examination 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, and that he will not be, on the day of graduation, under articles 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 by proper certificates.

Each candidate is examined both in writing and *viva voce*:—

1. On zoology, botany, physics, and chemistry.
2. On anatomy, physiology, and materia medica and therapeutics.
3. On pathology.
4. On medicine, surgery, midwifery, forensic medicine, and public health.

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.

Candidates who have passed the first and second divisions may be examined in the third division at the end of the fourth winter 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 one year in attendance on a hospital, or in scientific work bearing directly on his profession, or in the military or naval medical services, or for two years in practice other than purely surgical. 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 in 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 must show practical acquaintance with advanced methods of diagnosis; he *may* take, at option, gynæcology, mental diseases, or diseases of children for one of his three cases. The degree of M.D. is conferred on holders of the degrees of M.B., C.M. (Old Regulations), on the submission of a thesis approved by the Medical Faculty, provided that the candidate shall have passed the medical preliminary examination in the subjects of Greek and logic or moral philosophy. Should the candidate elect to do so, he may, however, take the M.D. degree under the new regulations, *i.e.*, substituting an examination in clinical medicine for that in Greek and logic. This course is usually pursued by those who did not pass in these subjects with the rest of their preliminary examinations.

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 regis tered 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 (Old Regulations, £5 5s.).

The total expense of the curriculum, including examination and matriculation fee, is £146.

Among scholarships, &c., open for competition during the Session 1906-7, are the following:—Syme surgical fellowship, £112; Goodyer Memorial fellowship in anatomy, £100 for two years; Allan Fellowship, £52, clinical, medicine and surgery; Eccles scholarship, £32; Sibbald medical scholarship, £40; Thomson scholarship, botany, zoology and Physics; £40; Vans Dunlop scholarship in preliminary subjects, £100; Crighton research scholarship in materia medica and pathology, £100. For the conditions attaching to these and a great many other fellowships, scholarships, bursaries and prizes the University Calendar should be referred to.

Graduation in Public Health: Degrees (B.Sc. & D.Sc.) are also 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 proceed for examination. Before proceeding to the first examination they must produce evidence that (1) they have worked 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 in addition to that qualifying for graduation in medicine, and one, of at least three months' duration, on geology, such as the Senatus 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, of at least forty lectures 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.

Diploma of Tropical Medicine.—Every year an increasing number of candidates avail themselves of the University Diploma of Tropical Medicine and Hygiene, which is conferred only on those possessing a degree in medicine. The course of instruction includes practical bacteriology, diseases of tropical climates, tropical hygiene, three months each; practical instruction on the zoological character and life history of disease-carrying insects and venomous animals—one month; clinical instruction at an hospital for tropical diseases—six months. The examination is held in January and July, the fee being £4 4s.

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, 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 many graduates 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, or other suitable person. These are considered and voted on at a house meeting. 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.—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. Women students are eligible for the benefits of the Carnegie Bequest.

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 instruction 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. A syllabus with full details of the curriculum and of the preliminary examination may be had, post free, on application to the assistant clerk, Matriculation Office.

The fees for M.B. and Ch.B. are £23 2s.; for M.D. £10 10s., and for Ch.M. £10 10s. For hospital attendance there is an initial fee of £10 10s., with a further fee of £3 3s., for each winter session, and £2 2s. for each summer session of clinical instruction. There are three very extensive general hospitals in the city, which afford exceptional opportunities for clinical work, while the Royal and other asylums, the City Fever Hospitals, the Maternity Hospital, the Sick Children's Hospital, the Eye Infirmary, &c., give facilities for the study of special branches.

The degrees of B.Sc. and D.Sc. in Public Health are also now conferred. Of late the University has made considerable efforts to extend its laboratory accommodation and equipment, to augment its teaching staff, and to encourage post-graduate and research work. Within the last few years there have been provided new laboratories in the departments of pathology, anatomy (costing £13,000), chemistry, and surgery (costing £9,900); while new laboratories, to cost, with equipment, upwards of £60,000, are now approaching completion, for the departments of physiology, materia medica, and medical jurisprudence and public health.

Bursaries and prizes to the annual amount of about £1,000 are appropriated to medical students, including an Arthur bursary for women, £20 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 in 1894. Fees for the classes at Queen Margaret College may be paid by the Carnegie Trustees; and several bursaries are open to women students of medicine.

The Winter Session begins on 18th October. The prospectus can be obtained from the hon. sec., Miss Galloway, Queen Margaret's College, Glasgow.

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. Total cost, exclusive of the fees for degrees, is about £120. 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 £1,180, 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 in any University in the United Kingdom. Regulations may be seen in the "Calendar," or obtained on application to the Secretary the Medical Faculty.

Aberdeen Royal Infirmary.—This is a well-equipped institution, containing 250 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 15th) grants the degrees of M.B., Ch.B., M.D., and Ch.M. 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. A Diploma in Public Health is also granted by the University of St. Andrews to graduates in medicine of any University in the United Kingdom. Twelve months must elapse between the date of graduating in medicine and entering for the examinations for the diploma. The course of study required consists of (1) a six months' course of practical chemistry, bacteriology, and the pathology of diseases transmissible from animals to man in a laboratory of the University of St. Andrews; (2) six months' work with a medical officer of health; (3) three months' clinical instruction in infectious diseases. Subjects for first examination :—Chemistry, physics, bacteriology, and meteorology. Second examination :—Sanitation, sanitary law, vital statistics, medicine in relation to public health.

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.—Malcolm bursary, £25 a year, tenable for five years). Fourteen Taylour Thomson bursaries, £30 to £20, five tenable for one year, nine for two, open to women only proceeding to graduate in medicine.

University College, Dundee.—Eleven entrance bursaries of £15, open to 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 28th, 1906, and March 24th, 1907. Schedules (obtainable from the Secretary of the University) to be returned filled up, and fees paid by September 15th, 1906, or March 13th, 1907.

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 10 guineas in each case. For the Diploma of Public Health examinations the fee is £5 5s. for each of the two examinations.

Class Fees.—The fee payable in each of the following classes is 4 guineas, *viz.*:—Chemistry, physics, zoology, botany, physiology, anatomy, materia medica pathology, forensic medicine, and public health, medicine, surgery, and midwifery. The fee for the practical classes in these subjects is 3 guineas each. In clinical surgery, clinical medicine, ophthalmology, diseases of the throat, nose, and ear, and mental diseases, the class fees are 2 guineas each. The fee for Public Health chemistry required for the D.P.H., is £7 7s. A special class in Bacteriology is also held for the D.P.H. for which the fee is 3 guineas.

Dundee District 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 Waymouth 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.

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 diploma 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 and surgery, as the case may be.

REGULATIONS OF THE CONJOINT 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, or the Superintendent of a 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 gynæcology, 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. H. Rainy, 16, Great Stuart Street, Edinburgh.

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 three years previously, and have attained the age of twenty-seven years.

The Membership is conferred only on a licentiate of a college of physicians or graduate in medicine of a British or Irish University, provided he shall have attained the age of twenty-four years and shall have passed an examination (1) On the principles and practice of medicine, including therapeutics; (2) on one of the following subjects to be selected by the candidate, *in which a high standard of proficiency is expected*:—(*a*) one or more departments of medicine specially professed; (*b*) psychological medicine; (*c*) pathology; (*d*) medical jurisprudence; (*e*) public health; (*f*) midwifery; (*g*) gynæcology. The examination is of a searching character extending over three days, the first of which is devoted to the examination of patients *viva voce*, and practical examination on methods of diagnosis —*e.g.*, microscopy of blood, clinical bacteriology, quantitative analysis, &c., and written commentary on a case examined. The second day is taken up by written papers, and the third by practical examination on special subject and orals.

The fee for membership is 35 guineas, for fellowship 38 guineas, with a stamp duty of £25—£101 13s. in all.

The licence, or single qualification in medicine, is conferred on candidates who already possess a recognised qualification in surgery. The examinations for this licence are held on the first Wednesday of each month, save those of September and October, in 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 gynæcological 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.

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 800 beds 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, diseases of the skin, eye, ear, throat and teeth, and anæsthetics. Separate wards are devoted to venereal diseases, diseases of women, diseases of the 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. The perpetual fee, on one payment, £12; the annual fee, £6 6s.; half-yearly, £4 4s.; quarterly, £2 2s.; monthly, £1 1s. Separate tickets 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 follow:—

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.

2. Non-resident physicians and surgeons (in the special subjects and for out-patient work) are appointed for six months. These appointments may be renewed.

3. Clerks and dressers are appointed by the surgeons and physicians. These are open to all students and junior physicians 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.

The government of this school, established in 1505, is now vested in a board which is equally representative of the two Royal Colleges and the Lecturers, the school being styled "The School of Medicine of the Royal Colleges, Edinburgh." The present number of lecturers is about sixty, of whom the greater number deliver qualifying courses of instruction of the same duration and scope as those delivered within the University, while a large number of non-qualifying courses on special subjects of interest to medical science, but which are not required for graduation, are delivered both in the winter and summer sessions. The students who attend the classes of the School of Medicine are largely students proceeding to the University degree, as well as those who are intending to take other qualifications, such as the triple qualification of the Royal College of Physicians of Edinburgh, the Royal College of Surgeons of Edinburgh, and the Faculty of Physicians and Surgeons of Glasgow; that of the Royal College of Physicians of London, and the Royal College of Surgeons of England, and the degrees of the different Universities. The number of students attending the school averages 1,300 annually.

The minimum cost of the education in the School of Medicine for the triple qualification 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 £120, which is payable by yearly instalments during the period of study.

The Winter Session opens October 2nd.

GLASGOW EXTRA-MURAL SCHOOL.

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 purpose of the medical school in the grounds of the hospital, and the laboratories, museums, and lecture rooms are of the most approved description. The college has been recently equipped with a complete electric light installation, and a powerful electric educational lantern. 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 over 600 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 78,000 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 eight surgeons' assistants, who obtain free board and residence in the hospital and act in the capacity of house physicians and house surgeons. 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 about £70.

Anderson's College Medical School, Glasgow.—New and excellently equipped buildings were opened in October, 1887, 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. There are also provided a library and reading room, and 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 dissections 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.

The various courses of instruction qualify for all the Licensing Boards in the United Kingdom, and for the Universities of London, Durham, Ireland, Edinburgh, and Glasgow, under certain conditions. The courses in public health (laboratory and lectures) are also recognised by the University of Cambridge.

The Carnegie Trust pays the fees of students at Anderson's College on conditions regarding which particulars may be obtained from W. S. McCormick, Esq., LL.D., Carnegie Trust Offices, Edinburgh.

Class Fees.—For each course of lectures (anatomy, ophthalmic medicine and surgery, aural surgery, diseases of throat and nose, and mental diseases excepted), first session, £2 2s.; second session (in Anderson's College), £1 1s.: afterwards free. For the following practical classes, *viz.*: Chemistry, botany, zoology, physiology, pharmacy, first session, £2 2s.; second session, £2 2s.; in botany and zoology, practical and systematic course together, £3 3s. Operative surgery, £2 12s. 6d. Public health laboratory, £11 11s.; with lecture, £12 12s. Opthalmic, medicine and surgery, aural surgery, diseases of throat and nose, mental diseases—eerch, £1 1s.

Anatomy Class Fees.—Winter: First session (including practical anatomy), £4 4s.; second session (including practical anatomy), £4 4s.; third session, £2 2s. To those who have had the necessary courses of practical anatomy, the fee will be £1 1s. Summer: Lectures and practical anatomy, £2 12s. 6d; separately, £1 11s. 6d. each.

Western Infirmary.—Fees: Hospital attendance. £10 10s. (permanent); clinical instruction, winter £3 3s., summer £2 2s., pathology, £4 4s. (systematic), practical pathology, £3 3s.; vaccination, £1 1s.

Royal Infirmary.—Fees: Hospital practice and clinical instruction, first year, £10 10s.; second year, £10 10s.; afterwards free. Six months, £6 6s.; three months, £4 4s.; pathology, both courses, £4 4s.; vaccination fee £1 1s.

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, 15, Dalhousie Street, Glasgow. Particulars may be had from D. M. Alexander, Esq., 97, West Regent Street.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Sept. 9th, 1906.

A NEW TREATMENT OF WHOOPING-COUGH.

HAVING administered chloroform to a child to reduce a luxation of the hip, who was at the same time suffering from whooping-cough, Dr. Henri de Rothschild observed that the fits of coughing had completely ceased after the anæsthetic. The patient was held under observation for a fortnight, but no return of the whooping took place, vomiting had also ceased as well as the cyanosis of the face and the insomnia.

This case led him to suppose that the inhalation of chloroform had a direct influence on whooping-cough, and since, that is to say, five months ago, Dr. Rothschild treated nine cases of well-pronounced whooping-cough. These children, of from two to seven years of age, were chloroformed with the consent of the parents, and all were cured, two immediately, four at the end of twenty-four hours, and three at the end of a fortnight. The duration of the anæsthetic was five minutes. The object in view was not complete anæsthesia with abolition of the reflex of the cornea, but muscular resolution. In no case was it necessary to use the chloroform a second time.

CHRONIC CATARRHAL LARYNGITIS.

Treat the cause, rest the voice (professors, orators singers), suppress tobacco, alcohol, etc., which are local irritants. The nasal fossæ and the pharynx should receive, says Prof. Lacroix, particular attention.

Prescribe balsamics (tolu tar, eucalyptus, benzoate of soda, terpine).

Besides thermal treatment, which is more local than general, sulphurous preparations may be given :—

Monosulphide of sodium ..	6 grains.
Syrup of tar	6 ounces.

A tablespoonful every morning in milk.

Nux vomica is very useful for the vocal cords, and in lymphatic subjects might be added arseniate of soda, iodide of potassium, or cod-liver oil.

The local treatment, the most important of all, consists in inhalations, pulverisations, nitro-laryngeal injections and applications of caustics or astringents.

Inhalations can be made without any apparatus :—

Phenic acid	½ drachm.
Cherry laurel water	2 ounces.
Water	2 ounces.

A teaspoonful in a half a glass of eucalyptus infusion. When boiling pour into a recipient and cover it with a funnel, with the small end up, through which the patient, will inhale the steam ten minutes morning and evening.

If a pulverisator is used, the following solution will be put into the boiler :—

Phenic acid	20 minims.
Cherry laurel water	1 ounce.
Water	20 ounces.

The best preparations for painting on the vocal organ are chloride of zinc and nitrate of silver. A weak solution should be used first (1–100) and the strength may be increased gradually to 1–50 or 1–30, which latter should not be exceeded.

GERMANY.

Berlin, Sept. 9th, 1906.

BOTTINI'S OPERATION *v.* PROSTATECTOMY.

THIS subject formed that of a paper by Dr. A. Frendenberg in *Heilkund*. The author had performed Bottini's operation in 152 cases of prostatic enlargement, some of the enlargements being due to cancer. the youngest patient was 41½, and the oldest 82. The operation was performed after long—often many years—prostatic troubles. It was never performed for acute retention of urine. There were 84 cures, 45 considerable improvements; good results therefore were obtained in 129 cases, or 84·9 per cent.; 12 failures were recorded, in addition to 11 deaths. The last 52 cases showed better results, viz., 90 per cent. of good results, 5·8 of failures, and 3·8 of deaths. Amongst the cures were cases in which complete retention had been present for 5 and 10, and once even 28 years.

In order to obtain good results with Bottini's operation it should first have been practised freely on the dead body. The operator must be skilled in intravesical surgery, especially cystocopy, and he should at least know how to perform a simple litholapaxy. Whoever does not fulfil these conditions had better stick to prostatectomy.

There will be cases in which the question will crop up, which is the better? Bottini's operation or prostatectomy? The author here lays down the following dicta:—First of all, the surgeon who has not great special experience in bladder surgery will do better to do a prostatectomy than Bottini's operation.

2. Bottini's operation is on the whole a much less serious one than prostatectomy, and should therefore in weakly and aged people be preferred.

3. In younger prostatics also it is to be preferred, having regard to potency.

4. Potentia coeundi is not endangered by Bottini's operation; on the contrary, power is often increased thereby, whilst prostatectomy when limited to the projecting tumour in the bladder often endangers it and the more so the more complete the prostatectomy. In case of the latter operation the patient should be instructed beforehand as to the probable impotence following it.

5. Bottini's operation is advisable in comparatively small and medium-sized prostatic enlargements. The magnitude of the operation and the probability of relapse increase with the size of the growth, whilst in prostatectomy mere size does not add materially to the difficulties.

6. If a *barriere* of the prostate causes the hindrance to the outflow, complete success will almost always be obtained by Bottini.

7. Spherical and pedunculated middle lobes are more suitable for prostatectomy.

8. If it is impossible to find out the condition before operation, and especially by means of the cystoscope, prostatectomy—the high operation—is generally to be preferred.

9. Calculi, so far as they can be removed by litholapaxy (with subsequent cystoscopic control), are no direct contra-indication of the Bottini operation, but they turn the scale in favour of prostatectomy.

10. Cystitis, with acid urine and pyelitis of moderate degree, are neither against the Bottini operation nor prostatectomy. But before operation the urinary condition must always be improved as much as possible. In ammoniacal cystitis the Bottini should not be performed until the ammoniacal reaction has been put right (this may be readily done by injection of iodoform or vioform or isoform), as otherwise the scabs will become encrusted with phosphates. During the after treatment also the urine must always be kept acid.

11. Bottini should not be done whilst fever is present. Prostatectomy, on the other hand, may bring about reduction of the fever by rest and drainage.

The author does not agree with what Roosing has said about so-called atony of the bladder being a contra-indication of Bottini's operation. There may be cases in which the muscular coats of the bladder have become so changed, that even when all hindrance with flow of urine is removed, the bladder does not regain the power of expulsion; but this is only very exceptional, and even then abdominal pressure will do a great deal. As a rule, the muscular coats of the bladder regain their expelling power, and this in a surprisingly short time, when once the hindrance to the outflow is removed.

The best interests of the patient are furthered when the question comes up whether a radical operation shall be recommended, by most carefully reckoning up the general condition, the kind and degree of obstruction with outflow of urine, but any supposed weakness of the muscular coats of the bladder may be almost or altogether disregarded.

HUNGARY.

Budapest, Sept. 9th, 1906.

At the recent meeting of the Budapest Inter-hospital Association Dr. Schmidt discussed the

Value of Tuberculin Reaction.

He proved that the tuberculin reaction is not infallible in tthe diagnosis of tuberculosis. His technique is as follows :—After absence of fever has been assured for several days by four hourly measurements, one m. of tuberculin in fiesh solution is injected, then after four to five days, five times this amount. In sixteen cases with positive reaction, tuberculosis was found at autopsy in only nine; in two carcinoma of the liver and stomach were the sole lesions, in five other pathological conditions. In one there was no reaction, yet evident tuberculosis. Despite such small doses and great care in injecting, serious accidents may occur, and a latent process may suddenly become active and even lead to a rapid fatal issue. This happened to the author in three cases—one of leprosy (in Bosnia) combined with tuberculosis, and one of affection of the serous membranes. A source of error is to be found in hysterical patients ; they sometimes re-act after tuberculin injections and even after injections of plain water.

Dr. Deak related his experiences with the treatment of ozæna. He said, that it has been suggested by several observers that some etiological relation existed between this disease and abnormal width of the nares, and the proposition was therefore made to influence the course of the process by diminishing the size of the opening. This may be accomplished by the injection of paraffin into the inferior turbinale bone, and Dr. Deak has employed the method in five cases. The nose is carefully cleaned and all crusts removed. The site of operation is then thoroughly cocainised, and the paraffin injected into the most atrophied part of the turbinate, and if necessary into the septum. Both sides may thus be healed at one or more sittings. All the cases showed distinct improvement, the relief from symptoms being very marked, although in no instance did a complete cure result. The only unpleasant sequelæ were pains in the frontal region in few cases, which disappeared, however, in the course of a day. Hard paraffin, with a melting point of 50 to 52 C. is recommended as being most suitable and safest.

Dr. Morelli discussed the question of the action of Rontgen Rays. Most observers believe that the skin is affected primarily and most strongly by the X rays if a portion of the body is exposed to their, influence, but Morelli made the startling statement that the blood vessels re-act before the skin. All lesions of the skin and connective tissue are thus an expression of nutritive disturbance secondary to vascular alteration. The following experiments support this view :—If a diseased area of skin is excised the raw surface may be covered with skin-graft which will rapidly heal in place. If the skin is first exposed to the Röntgen Rays before it is transplanted the healing will be just as rapid, while an equal amount of exposure where the skin is not removed will lead to superficial ulceration. One may even preserve the exposed grafts for two days in normal salt solution and then transplant them successfully on some other individual, showing that there is not the slightest loss of vitality. If a granulating surface is exposed and then covered with normal grafts, these will be cast off a few days later. The cornea of a rabbit will not be influenced by an exposure which causes falling out of the hair in other parts of the body, simply because the cornea contains no blood vessels. The blood itself does not seem to be affected by the X-rays, for even prolonged exposure both in vivo and in vitro, did not change the microscopical appearance or the hemolytic power. The most important systemic reaction after exposure is a slight increase in temperature, and an increased metabolism, manifesting itself in an abundance of nitrogenous material in the urine.

LETTERS TO THE EDITOR.

TRUTH AND THE MEDICAL PROFESSION.

To the Editor of the Medical Press and Circular.

Sir,—No doubt it is of immense importance that *Truth* should have taken up alone among lay papers the championship of the medical profession. The value of this championship may be perhaps inferred from the character of the numerous medical advertisements which appear in its pages. Perhaps you will allow me to enumerate a few of these which have been published in the last two numbers. The issue of August 29th contains an advertisement of "Dr. Alabone's Treatment for Consumption, which has succeeded in restoring to perfect health many who had been given up as '*incurable*' by eminent consultants." On another page of the same number a column advertisement describes the virtues of "Sanatogen," which, "through regenerating the nervous system restores the functions of the digestive organs, and by rebuilding the whole body compensates the wear and tear of latter day life." The issue of September 5th contains an advertisement of "Reveille Pills," "a positive cure" for ten named diseases, including "anæmia, dyspepsia, and all nervous affections." The same number contains advertisements of "Hair Capsuloids," "Harrod's Cure for Asthma," "Beecham's Pills," "Mrs. Adair's Certain Cure for Double Chins," "Phosferine, the greatest of all Tonics," "Clarke's Blood Mixture," which permanently cures a number of diseases, including "scrofula, blood poison, rheumatism, gout and skin diseases," and the Turvey treatment of alcoholic excess and the drug habit, which are "cured at home in three to seven weeks." Not the least interesting among these announcements is Mr. Labouchere's personal testimonial in praise of "Goodman's, Ltd.," "originators of the popular guinea sets of artificial teeth."—I am, Sir, yours truly,

An Obscure Practitioner.

ARMY (REFORM) BREAKDOWN AND ENTERIC FEVER.

To the Editor of The Medical Press and Circular.

Sir,—Notwithstanding the statement that 'enteric is in all cases a water-borne disease," I cannot help thinking that numbers of cases of death among our troops in South Africa (entered under the heading enteric) were far more likely to be genuine cases of ptomaine poisoning, and I am the more confirmed in this conviction by the reply given to a member, who at my suggestion, asked the question in the House : How much of the meat supplied to our troops had come from Chicago in tins ? The reply being, "*more than half.*" This reply should give grounds for thought; and if it is the fact (which I have heard more than once) "that a post-mortem examination is made on the body of every soldier dying from disease while on active service" it should make it all the more unlikely that so many should be listed under the convenient heading of enteric fever during the South African war.—Yours, &c.,

[Alexander Duke.

London, W.

NOTICES TO CORRESPONDENTS, &c.

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

CONTRIBUTORS are kindly requested to send their communications if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

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 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 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.

GRATUITOUS COPIES.

A VERY large number of copies of this issue are being sent gratuitously to all the educational establishments, hospitals, reading-rooms, clubs, and large hotels, in the United Kingdom, and to a large number in America, India, the Colonies, and on the Continent; should any of our readers desire to present a copy to a patient or friend who contemplates sending his son to a medical school, our publisher will be happy to supply him with a duplicate free of cost on receipt of address.

COACHING FOR THE EXAMINATIONS.

STUDENTS desirous of coaching facilities in preparation for the various College Examinations, and practitioners anxious to obtain the Diploma of Public Health, are referred to the announcements of Mr. E. Gooch, B.Sc., and of Mr. E. S. Weymouth, M.A.Lond., on page xl. of our present issue.

DR. RABAGLIATI'S letter is unavoidably crowded out of our present issue.

DR. F. (Oban).—The decisions of the Privy Council are not always reasonable. You are right in saying that ten articles were scheduled by the Pharmaceutical Society as poisons, but three, acetanilide, soluble salts of oxalic acid, and sulphonal were excluded by the Privy Council.

D. P. H. (Worcester).—The late Mr. Noble Smith took great interest in school hygiene, and devised a couch on which children could recline and study. It could be screwed up to accommodate any child.

IGNOBUS.—The Municipal Officers' Association has been in existence some twelve years and is in a strong position. We should advise you to join it and bring the matter before their notice.

W. (Dover).—Eau de Cologne can hardly be classed as a drug, and in any case it would be liable for duty. Under the circumstances it is better left behind.

SPA.—The trout fishing is said to be very good, and we believe this is not an angler's tale of the usual kind. The other advantages are as described.

BRADFORD.—The ordinary commercial substance, we believe, is never free from some trace of acid. Peroxide of hydrogen should always be kept in good strong bottles, or in those with a loose stopper, through which any oxygen formed may escape.

X. (Dundee).—The birth rates for the towns you ask about were, for the month of July, as follows:—Greenock, 34·5; Glasgow, 28·7; Leith, 27·7; Dundee, 26·9; Paisley, 26·8; and Edinburgh, 21·7. 7·6 per cent. of the births were illegitimate.

ANTIFLEXION.—The growth may be benign, but tumours arising from the external genitalia are generally malignant. You should certainly have a section of the growth cut and examined by a pathologist.

CHESHIRE.—Each medical inspector in New York visits the schools in his group and in a special room he examines all children suspected by teachers to have contagious diseases, all children who have been absent from school, and all cases indicated by the school nurse.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, SEPTEMBER 12th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—10 a.m.: Diseases of the Throat, Nose, and Ear. Diseases of Children. 2 p.m.: Medical and Surgical Clinics. 2.30 p.m.: X Rays. Operations.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. J. Clarke: Clinique. (Surgical.)

THURSDAY, SEPTEMBER 13th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—2 p.m.: Medical and Surgical Clinics. 2.30 p.m.: X-Rays. Operations. Diseases of the Eye.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical).

FRIDAY, SEPTEMBER 14th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—2 p.m.: Diseases of the Throat, Nose, and Ear. Medical and Surgical Clinics. 2.30 p.m: X-Rays. Operations. Diseases of the Skin.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. L. Paton. Clinique. (Eye.)

SATURDAY, SEPTEMBER 15th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—10 a.m.: Diseases of the Throat, Nose, and Ear. 2 p.m. Medical and Surgical Clinics. 2.30 p.m.: X-Rays. Operations.

Vacancies.

Manchester University.—Junior Demonstrator in Physiology. Salary £100 per annum. Applications to the Registrar.

Metropolitan Hospital.—Casualty Officer. Salary £150 per annum. Applications to Charles H. Byers, Secretary and House Governor.

Egyptian Government.—Ministry of Education.—Professor of Midwifery and Gynæcology. Salary £400 a year, with private practice. Applications to the Director, School of Medicine, Cairo, Egypt.

Egyptian Government.—Ministry of Education.—Medical Tutor and Registrar to Kasr-El-Ainy Hospital. Salary £400 a year. No private practice. Applications to the Director, School of Medicine, Cairo, Egypt.

City of Birmingham Asylum, Rubery Hill, near Birmingham.—Assistant Medical Officer. Salary £150 per annum, with furnished apartments, board, &c. Applications to the Medical Superintendent.

Camberwell House Asylum.—Second Medical Assistant Officer. Salary £150 per annum, with board, apartments, and laundry. Applications to the Medical Superintendent.

Manchester Children's Hospital, Pendlebury.—Assistant Medical Officer. Salary £100 per annum. Applications to the Secretary of the Hospital, Pendlebury, near Manchester.

Cardiff Union.—Assistant Medical Officer. Salary £130 per annum, with rations, apartments, attendance, and washing. Applications to Arthur J. Harris, Clerk, Union Offices, Queen's Chambers, Cardiff.

Great Northern Central Hospital, Holloway. — Pathologist and Curator. Salary £100 per annum. Applications to L. H. Glenton-Kerr, Secretary.

Leicester.—Resident Assistant Medical Officer (Poor Law Infirmary). Salary £120 per annum, with rations, furnished apartments, and washing. Applications to Herbert Mansfield, Clerk to the Guardians, Poor Law Offices, Leicester.

Sussex County Hospital, Brighton.—House Surgeon. Salary £100 per annum, with board and residence in the hospital, with washing. Applications to the Secretary.

Royal London Ophthalmic Hospital (Moorfields Eye Hospital), City Road, E.C. Founded 1804.—Senior House Surgeon. Salary £100 a year, with board and residence in the hospital. Applications to the Secretary.

Bromyard Union.—Medical Officer required for No. 1 District.—Particulars of E. L. Cave, Solicitor, Bromyard. (See advt.)

Fermanagh County Infirmary.—House Surgeon. Salary £52 per annum. Applications to Mr. C. Wilson, Secretary. (See advt.).

Appointments.

GERATY, LAURENCE, M.R.C.S.Eng., L.R.C.P.Lond., Medical Officer of the No. 9 District of the Lincoln Union.

HARPER, FRANCIS MARGARET, M.B., Ch.B.Edin., D.P.H.Camb., Lady Assistant Medical Officer to the County Borough of St. Helen's, Lancashire.

JORDAN, ALFRED C., M.D.Cantab., Medical Officer to the Electrical Department of the North-Eastern Hospital for Children, Hackney Road.

NICHOLLS, FRANK J., M.B., B.C.Cantab., M.R.C.S., L.R.C.P.Lond., Medical Officer to the London County Council Training College, Avery Hill, Eltham.

STOCKER, EDWARD GAVED, L.R.C.P.Lond., M.R.C.S.Eng., temporary Medical Officer and Public Vaccinator for the Clevedon District, Somerset, by the Long Ashton Board of Guardians.

TAYLOR, CLIFFORD J., F.R.C.S.Edin., House Surgeon to the Herefordshire General Hospital.

WHITE, GEORGE F., M.D.Dub., Certifying Surgeon under the Factory and Workshop Act for the Stanford-le-Hope District of the county of Essex.

Births.

McDOUGALL.—On Aug. 5th, at Benloyal, Woodcote Road, Wallington, Surrey, the wife of William Stewart McDougall, M.B., C.M., of a daughter.

Marriages

LATHAM—LARSEN.—On Aug. 23rd, at the Cathedral, Trondhjem Norway, Arthur C. Latham, M.D.Oxon., Physician to St. George's Hospital, London, son of P. W. Latham, M.D., late Downing Professor of Medicine, Cambridge University, to Ella Augusta Petrea Larsen, youngest daughter of the late Herr Peter Larsen, of Aarhus.

Deaths.

ADAMS.—On Sept. 6th, at Hove, James Adams, M.D., M.R.C.S., late of Barnes, in his 77th year.

SMITH.—On Sept. 5th, accidentally drowned while boating, Leslie Ernest Maule Smith, M.R.C.S., L.R.C.P., only son of Dr. E. and Mrs. Barratt Smith. Aged 24.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIII. WEDNESDAY, SEPTEMBER 19, 1906. No. 12.

NOTES AND COMMENTS.

Swansea's New Asylum.

IT is a curious thing that during the last few months there should have been much trouble about the Welsh asylums. We have already commented upon the election of an asylum superintendent at Cardiff in which improper influences were alleged and much feeling exhibited, and also on the adverse report of the Lunacy Commissioners on the Joint Counties' Asylum where what is everybody's business is neglected because nobody can decide whose business it is. Now there is trouble at Swansea. Last week the General Purposes Committee of the Corporation met to discuss the question of the site of a new asylum which it proposes to build. A careful report from one of the Lunacy Commissioners was read in which the site was approved in a general way, if certain conditions were adhered to and certain additional suggestions carried out. The Chairman of the Asylums Committee moved that they should adopt the site, subject to a satisfactory report by an expert, and named a gentleman for the purpose. This name was opposed, and the Chairman of the meeting stigmatised a letter the gentleman in question had written to the Chairman of the Asylums Committee as "very nearly indecent," the expert being obviously anxious to demonstrate his own suitability for the job. Then followed an unseemly dispute which ended in the Chairman quitting the chair, and general unpleasantness all round. To those at a distance Welsh lunacy administration does not seem to be in a very happy condition, and allegations of improper influence are not calculated to increase public confidence.

Sanatorium Finance.

THERE is an element of tragedy about the reports of some of the sanatoria that are issued from time to time. At the beginning of what may be called the tuberculosis "boom," people were converted in large numbers to the gospel of fresh air and sanatoria and flushed with enthusiasm they started building sanatoria and giving donations. Throughout the country on rising knolls and breezy uplands rose comfortable buildings which were expected to restore to health and efficiency consumptive workers of all sorts and conditions, and counsels of caution were hardly heeded. A little worldly wisdom would have taught responsible people that after every excitement comes a reaction, and that when a reaction sets in every circumstance that can increase the depression is called in to account for it. Signs of such a reaction with regard to sanatoria are not wanting, and if we mistake not there are likely to be still more in evidence before a normal balance is established between expectation and accomplishment. At a meeting held at Bath on the 12th of this month, the affairs of the Winsley Sanatorium were discussed, and a highly unsatisfactory state of affairs was revealed. The Sanatorium is already £15,000 in debt, and requires £900 a year more than it is receiving to keep it going. Moreover charges of extravagance on initial outlay on building and dissatisfaction at the therapeutical value of the institution have apparently estranged sympathy, and at the best only 60 beds are provided for a population of one and three-quarter millions of people. At the meeting a resolution was proposed, and eventually passed, to raise £7,500 on mortgage in order to pay off the more pressing creditors, but it seemed to be generally recognised that unless far more liberal regular support was forthcoming the Sanatorium would find itself involved in serious financial difficulties. We sincerely trust that the locality will rise to the occasion and remove the reproach of niggardliness that lies upon it; but the incident is not without significance, and should be carefully noted by those who are thinking of embarking on similar enterprises.

Conveyances and Small Pox Patients.

THERE has been some unpleasantness at Limehurst, near Ashton-under-Lyne, because a doctor allowed a lady patient whom he found to be suffering from small pox, to walk to the hospital. On the face of it such a proceeding wears the appearance of negligence, and the Limehurst District Council wrote an indignant letter to the doctor demanding an explanation, and pointing out that he was liable to prosecution under the Public Health Act. The doctor replied that the patient in question absolutely refused to go to hospital in the van, and that he as resolutely opposed her going in a cab. Here was a dilemma. He was determined to get her into hospital however, and the best course under the circumstances was to make her walk; so recourse was had to the old device—*solvi tur ambulando*. As the route lay through a quiet country lane, and no one was met on the way, we really think the Council might write to congratulate the doctor on his tact in overcoming the difficulty of getting the

patient to hospital, instead of holding solemn conclaves and breathing out threats because of a technical irregularity in the course he adopted. The public seldom appear more foolish than when they are brought into contact with the question of infection; partly through ignorance and largely through fear, they generally manage to do, say, or write grotesque things which they would hardly do in their sober senses.

Small-pox in Out-Patients' Rooms.

WHAT, for instance, is the right course for a physician to take when he sees a man with small-pox seated on a bench with other out-patients quietly waiting their turn? In some of the larger and more modern hospitals there are special isolation rooms, but such is not always the case, and the choice of what is to be done lies between two evils. This particular situation presented itself to a medical friend of ours some little time ago, and with admirable promptitude he called the small-pox patient out and walked him up the middle of the street to the nearest ambulance station. Legally, no doubt, the doctor was wrong, and some fussy councils would have been delighted of the occasion to prosecute him; but common-sense and legal obligation do not always point the same way. At any rate this course was better than that adopted, or—which is not always the same thing—said by the patient to have been adopted, by a practitioner in London a few years back. The man was summoned for exposing himself in the Underground Railway while in an infectious state, and his story was that he had been to a doctor who told him he was suffering from scarlet fever and should go to hospital. The best way of accomplishing this was discussed, and it was finally decided that he should travel by the underground railway because the quantity of sulphur in the atmosphere would be sufficient to emasculate any germs that might emanate from him.

LEADING ARTICLE.

BRENTFORD HOSPITAL SCANDAL.

WE were unable to comment last week on the scandal at the Brentford Isolation Hospital owing to the fact that that issue was devoted to the special interests of students, but the incident is one that is worthy of special attention. It appears that three children of one of the Corporation employés at Ealing were inmates of the hospital in question, and the father was so dissatisfied at the treatment they received that he wrote a public letter of complaint to the Council. The Council deliberated over the subject of this letter and made their inquiries with closed doors, so that whatever happened at their meeting can only be guessed at by their decision to dismiss the superintendent nurse and severely to censure other officials. It is asserted in various papers that there have been many other complaints against this hospital from time to time, that its administration is badly conducted, and that representations were made to the Local Government Board.

In one respect, therefore, it seems that the Brentford Isolation Hospital is like a good many of its class, namely, in forming a frequent source for complaint and dissatisfaction among those whom it serves, and if we turn to the letter of the complainant who raised the recent to-do, we find a typical example of these complaints. The first is, that one of his girls was sent home from the hospital after scarlet fever "as properly cured and disinfected on July 3rd," and that on July 11th his other two children were found to have scarlet fever and stood in need of removal to hospital. Although we are not informed how long the first patient was detained, it is perfectly reasonable to assume that she passed the usual period of six or eight weeks there, and was "disinfected" when she came out, but that, like some four or five hundred similar cases in London every year, she proved to be infectious although no sign was visible on her discharge. The father asserts that the child "peeled" after her return home, but it is well recognised not only that secondary peeling may go on for many weeks after scarlet fever, but also that there is no evidence that such desquamation is infectious. The complaint, then, so far, if the facts be as we assume, should not be against the administration or the officials, but against the disease from which the child suffered, for its not conforming to the regulations which are laid down for it in text-books, and on which the isolation hospital system was founded. The next point in the father's letter is that the children who were infected by their sister were, on removal to hospital, placed in a ward where there was an outbreak of measles, and that one child caught this disease and died. Here, again, we have a substantial complaint; no one can deny the hardship, and no one can compensate the father for the loss of his child. At the same time—we speak in ignorance of the actual accommodation—in isolation hospitals where the number of wards is relatively small and a large proportion of the patients are children, it often happens that there is no suitable accommodation, except in a ward where whooping-cough, measles, chicken-pox, diphtheria, or some other infection is present. If it is anybody's fault it is that of the ratepayers for not providing sufficient accommodation for every disease and combination of diseases that child-flesh is heir to. The other two complaints, that the child was allowed to stay too long out of bed, and that no nurse "walked" the ward during the night, are (if true) either the result of improper supervision or to that frequent cause of trouble in isolation hospitals—under-staffing. Where numbers rise and fall in isolation hospitals as they continually and constantly do, the task of keeping the staff at a level sufficient to cope with emergency and not too high to call forth the wrath of economists, is an invidious one for even the most accomplished administrator. The grand rule that guides the management of many of these hospitals is to muddle along as well as possible till a scandal arises, and then to dismiss an official. Whether this

was so at Brentford or not we cannot say on the evidence available, but we think we have said enough to show that, so great are the difficulties in satisfactorily managing these hospitals, it is a grave question whether it is wise to continue to spend the enormous sums their upkeep entails in the indiscriminate removal of all scarlet fever cases. The Brentford case gives point to what we have so often urged, namely, that the moment is ripe for a full inquiry into the results of the working of the system.

NOTES ON CURRENT TOPICS.

Law for Lawyers and Law for Doctors.

Some weeks ago, under the above heading, we commented upon certain cases in the police and criminal courts illustrating the law as it affects illegitimate practice in the legal and medical professions respectively. If the underlying facts could be impressed upon the public and Parliament it is impossible to believe that the present state of things would be allowed long to continue. A case heard at Marlborough Street Police Court on Tuesday in last week once more showed how complete is the protection afforded by the law to lawyers and to the public in the matter of practice by the unqualified. A man was fined £5, with £3 3s. costs, for sending a letter demanding payment for a debt and containing expressions which might be construed to imply that the writer was a solicitor. Under medical law no equivalent prosecution is possible. Unless a quack is foolish enough to assume a title distinctly named in Medical Acts, he may adopt any method he chooses to lead the public to take him for a fully qualified man; and there are hundreds of fraudulent quacks throughout the country practising under such false pretences. Many, or most of them, publish advertisements which lead their readers, and even educated readers, to look upon them as qualified medical men. No one has any power to interfere with these rogues so long as they do not violate common law; and there exists no public prosecutor and no body like the Law Society to take proceedings, even when flagrant violation of Medical Acts is committed. It is for the complete exposure of these anomalies that the appointment of a Royal Commission is so urgently demanded.

The Coroner's "Special" Pathologist Question.

Many obstacles have arisen in the spirited defence of their professional interests by the medical practitioners of South London against the arrogant inroads of a certain coroner, and the particular policy of the London County Council in advocating so-called "expert" pathologists. Perhaps one of the most serious reverses to the movement has been the decision of Mr. Cockerton, Auditor of the Council's accounts, to the effect that the disbursements made by Mr. Coroner Troutbeck in payment of Dr. Freyberger were legal. It is well to bear in mind, however, that Mr. Cockerton added his opinion that the Coroner's Act of 1887 never contemplated the employment of a special pathologist in the manner adopted by the coroner. He therefore recommended the passing of an amending Act, but whether in the interests of the Council or of the medical profession is not clear. The *South London Press*, in commenting on the matter, says naively that the incident may now "be said to be closed." With all due deference our worthy contemporary may be assured that there is little chance of the incident ever being closed except on a basis of ordinary commonsense justice and respect for the rights of an honourable profession.

Postage Stamp Paper for Cuts.

The history of popular remedies has yet to be written, but should it ever emerge into the light of day it will bristle with a grim host of tragedies. Medicine herself has, indeed, thanks to the genius of Lister, recently grasped the ideal treatment of wounds by the exclusion of harmful bacteria. It is, of course, now open to the truly enlightened housewife to keep at hand some simple antiseptic dressing, such as Condy's Fluid, weak carbolic lotion, boric ointment, and boracic acid lint and cotton wool. By the use of such remedies all ordinary cuts and other small injuries involving the skin may be treated with confidence as within the range of legitimate household surgery. If ordinary sticking-plaster, unsterilised rags, and other germ-laden dressings be applied, the results from even a trifling cut may be disastrous. Abscesses, blood-poisoning, lockjaw, prolonged ill-health, and rapid death may ensue from a tiny septic cut or abrasion. A few weeks since an inquest in point was held at Oxford upon the body of an elderly lady who had knocked a piece of skin off one of her hands, and dressed the wound with a piece of the gummed edging of postage stamps. The arm was poisoned, and she died within a few days. Postage stamps are peculiarly liable to become septic and to convey deadly germs: a fact that cannot be too widely known to the public who find in it a popular substitute for sticking-plaster.

Mortuary Porters and Post-mortem Examinations.

The familiar question of what amount of help medical men may fairly look for at the hands of mortuary attendants has cropped up in an acute form at Cardiff. A member of the local Health Committee recently startled that body by alleging that in numerous cases of *post-mortem* examinations, for which medical men were paid, the bodies were opened and the organs cut out and placed on the table by the caretaker, who afterwards replaced the organs and sewed up the body. This statement has been emphatically denied by the caretaker himself, as well as by the district police surgeon and other prominent medical men. So far as Cardiff is concerned, the matter will doubt-

less be impartially sifted. As regards the general question, it is hardly necessary to point out the absolute desirability of the medical man carrying out with his own hands the whole of the *post-mortem* except, perhaps, the restoring of organs and stitching up of the body. Any other course might obscure or destroy valuable evidence upon which reputation or even life might depend. Some of our readers may recall an incident of the kind in which a much talked of London "expert" was concerned. The case was one in which the interest centred upon a tracheotomy wound The pathologist arrived on the scene shortly before the opening of the inquest, and all the organs, including the trachea, had been removed, and neatly arranged on the table by the porter! In a criminal inquiry an act of that kind might be quite enough to invalidate all evidence arising from a *post-mortem* examination.

Lord Kitchener and Typhoid Fever.

AN excellent example has been set by Lord Kitchener in India in appointing a Standing Committee on Enteric Fever, but we hardly expect that its influence will extend to Pall Mall. The value of proper hygienic knowledge in the prevention of disease is dawning very slowly on the British Army authorities, but in India where intelligence is a passport to high places and the army has to be kept on a businesslike footing, it has long been recognised that money invested in the proper clothing, feeding, and care of soldiers is well-laid out. Enteric fever, it is curious to reflect, was always supposed to be non-existent in India, and even now there are those who cherish a distinction between "tropical typhoid" and temperate zone typhoid. But, however it be regarded or classified, there is no doubt that enteric fever is a great danger to Europeans in India, especially to those who are young and newly-arrived. The attack and mortality rates among the British troops are still unreasonably high, and it is good news indeed that systematic effort is to be made to reduce them. Cholera has lost nearly all its terrors for the white population of India, and there seems no good reason why enteric should not follow suit. Lord Kitchener addressing the first meeting of the Committee, spoke principally on anti-typhoid inoculation, which is regarded as a settled practice by the medical authorities in India. The difficulty in many cases is to get the soldiers to allow the inoculation to be performed on account of the initial pain and inconvenience, and Lord Kitchener asked his hearers to consider carefully whether it would not be possible to make the process less painful either by actual improvements in it or by using smaller doses, and reducing the length of the period of immunity gained. He also commended to their consideration the important question of examining the blood of men who had had enteric, and were possibly disseminating the disease by retaining the bacilli in their organs. The Committee, we may be sure, will have strong support in any action they advise from a man who carries efficiency to the point that Lord Kitchener does.

The Marienbad Cure.

"TURTLE," said Lord Beaconsfield, "makes all men equal," and the same assertion can be made of those who seek to be patched up after a superfluity of turtle. King and commoner alike find benefit from a "cure," and they can both avail themselves of it on one condition, namely, that they pay the piper; so at Marienbad, Homburg, and Aix they meet on the common level of suffering humanity. But, knowing the natural tendencies of mankind, one can be certain that at the spa where the King gets the most good, his loyal subjects will find that they, too, get on best. Therefore the lamentations of the English spas, of which so much is to be read in the newspapers now that the season is closing, are no doubt justified. It is ridiculous to suppose that the cleansing virtues of sodium sulphate are more efficacious at Carlsbad than at Harrogate or that iron benefits chlorosis more at Aix than at Tunbridge Wells, especially as it is possible when necessary to drink the water of any one spa at any other. The popularity of Continental resorts is regrettable from the point of view of British capital invested in home spas, but indignant letters to the papers will not alter the fact. No doubt spa-caterers at home have a good deal to learn both as regards the judicious management of their guests and the accommodation of charges to pockets; but, after all is said and done, the matter is one of habit and fashion, and till these are broken through, the British spa, woo it never so wisely, will not attract the host of livery and obese plutocrats which throng the Continental resorts. Oliver Wendell Holmes has said that "habit is an action in present circumstances from past motives," and till the habit of being cured at home is formed, mankind, impelled by past motives and desire to drink solutions of Epsom salts next a Russian princeling or German baron, will continue to go abroad when it wishes thoroughly to "enjoy" its bad health.

Scarcity of Medical Men.

A NOTICEABLE amount of correspondence has been going on in various journals about the scarcity of doctors, and we are sure that a good many practitioners wish that the scarcity existed in fact as solidly as it does in the imagination of the writers. A walk down the chief streets of an ordinary town should, we would fancy, tend to undeceive any unbiassed person on the score of medical scarcity. No doubt every trade and profession as a whole is apt to take a pessimistic view of the competition with which it finds itself faced, but this much at least may be said, that the public may rest assured that they never need want for doctors, and good doctors, in any part of the British Isles. It is equally undeniable that if competition were a little less keen, the status and remuneration of medical men would be much improved, not in the subordination of the public interest to the medical, but in the increased opportunities for the good work and culture that would be possible for the medical men. Many now have little leisure for self-improvement and the advancement of their own knowledge and dexterity,

owing to the difficulty of making a living out of the small fees they receive, and such a state of affairs cannot be considered fully advantageous to their patients. The scarcity of doctors, if it ever exist, would soon rectify itself if the prospects of doctors were improved.

The Sources of Government Lymph.

In our columns this week will be found some letters which have passed between Sir William Collins and the President of the Local Government Board as to the sources whence the Government supply of vaccine lymph is derived. In the House of Commons on June 28, Sir William Collins asked Mr. Burns for a return showing the original sources of the vaccine lymph which had been, or now is, in use; but this return was refused, and Sir William was asked to put another question on the subject. The reply to this further question was far from conclusive, and in pursuit of his object Sir William Collins opened the correspondence which we now publish. The point at stake may seem at first sight an academic one, but if it be closely regarded, it will be seen to be not without interest, both scientifically and politically; scientifically because of the difficulties that attend the diagnosis of true vaccinia in animals, and politically because of the controversial utility to opponents of vaccination of this admission by the Government that they are unacquainted with the ultimate sources of the lymphs they issue. The strength of the prejudice against vaccination which exists in many parts of the country is hardly realised by those in authority, it has long passed out of the domain of reason and entered that of passion. Now it is the business of statesmen, if they wish to reconcile people to the vaccination laws, to remove from their path every obstacle, real or imaginary, and we hardly think the Local Government Board are to be congratulated on the way they emerge from this correspondence. They doubtless took the most detailed care in selecting the sources of their stocks to make certain not only that they had lymph free from extraneous contamination, but also that it was of proved efficiency, and we quite believe that the lymph actually in use now is good and efficient vaccine lymph; but why, it may be well asked, go to Cologne and to other Continental resorts for this lymph? If there be any peculiar efficacy in their strains it should be capable of being easily explained, and it is a pity that the department do not see their way to do so.

"Silly Season" and the Medical Profession.

The silly season has, as usual, produced a crop of attacks on the medical profession. Year after year, irresponsible scribblers are able to earn an honest or dishonest penny by sensational articles which suggest that one or other branch of our profession is composed of unscrupulous scoundrels. One year we learnt that it is the custom of general practitioners to act on commission as touts for undertakers, if not indeed to provide material for the industry of that class. This year, a gentleman, who signs himself "Hew Ronald" discourses glibly in the *Sunday Chronicle* of "How Sane Men and Women drag out their Lives in Private Asylums, whilst Rogues batten on their Fortunes." Mr. Hew Ronald seems to be rather unfortunate in his friendships, since he boasts of having quite a number of friends in these deplorable circumstances. The natural thing for Mr. Ronald to do would be to draw the attention of the Lord Chancellor or the Inspectors in Lunacy to this scandalous state of affairs, but doubtless it pays him better to write two columns on the subject to a weekly paper. In these columns we hear much of "venal and unscrupulous doctors," and from them we learn that "there is a powerful section of the medical profession who are directly interested in depriving sane people of their liberty." On the other hand, we breathe again at the admission that "there are good mad doctors and good asylums." According to Mr. Ronald, there is nothing easier than to lodge a sane person in an asylum, and nothing more difficult than for that person to get out. It would, perhaps, not be irrelevant to suggest that while there are good journalists and good papers, there are also "venal and unscrupulous" writers who are willing to do a "dirty job" not perhaps for an "enormous fee," but for the modest and traditional penny-a-line.

In the special Army Order promulgated on Saturday last it is appointed that six of the most meritorious officers of the medical service on the active list shall be named the King's honorary physicians and six honorary surgeons. On appointment as an honorary physician or surgeon an officer under the rank of colonel in the Medical Corps may be promoted to the brevet rank of colonel. On retirement an officer must relinquish the appointment of honorary physician or surgeon.

PERSONAL.

Last week, Dr. Wolfenden, of London, with his two sons, had a narrow escape on a runaway motor, while touring on the Welsh mountains. The car was smashed to pieces, but the only serious injuries reported are a broken collar bone in one of Dr. Wolfenden's sons, who was pinned under the car, and a dislocated shoulder sustained by the chauffeur.

The Bishop of Bristol will deliver the inaugural address and present the prizes to students at the opening of the winter session of St. George's Hospital Medical School on October 1st.

Dr. Morris Travers, Fellow of London University, and Professor of Chemistry at University College, Bristol, has been appointed Director of the Indian Institute of Science, which is to be established in Bangalore.

The Inaugural Address at the Meath Hospital Dublin, of the Session 1906-7, will be delivered on Monday, October 8th, by Sir Lambert H. Ormsby, senior surgeon to the hospital.

On the occasion of his departure from Blagdon after many years of practice, on account of failing health, Dr. Richard Brown, M.B., was last week presented with a silver bowl and a cheque for £233 by his friends in the neighbourhood.

The King is reported to have benefited much in health from his recent stay at Marienbad.

Dr. Howard A. Kelly, of Johns Hopkins Univ. arrived in London this week, en route for the Quater Centenary at Aberdeen.

A CLINICAL LECTURE
ON
TECHNIQUE AND INDICATIONS FOR LUMBAR ANÆSTHESIA.

By R. LUCKE, M.D.,
Specialist in the Diseases of Women.

THE attempts to produce sufficient diminution of sense of pain for purposes of operation in the lower half of the body by the injection of anæsthetics into the spinal canal date from 20 years ago. In 1885 Corning tried to attain this object by injecting cocaine between the 11th and 12th dorsal vertebræ, and his technique differed from that usual to-day in that independent of the choice of spot he avoided injecting into the spinal canal itself; he injected therefore extradurally, a precaution that was justified by the choice of the site of injection. Only in 1894 did Corning inject the cocaine into the spinal canal itself, and at a spot where injuries to the cord were no longer to be feared, *i.e.*, between the 3rd and 4th lumbar vertebræ. In Germany, Bier before all others has done good service in working out the process; he experimented on himself, and in spite of results not altogether satisfactory at first, did not cease his attempts to perfect the process. In France also the procedure awakened great interest mainly through Tuffier, which, however, was speedily extinguished owing to an impression that bad results accompanied and followed the injection of cocaine. It was these bye-effects that mainly stood in the way of the general introduction of lumbar anæthesia, and we find therefore a series of experiments with other and less poisonous preparations in the place of cocaine, for example, B. eucain, tropacocaine, and many others. Both the substitutes mentioned have found employment, especially in Austria. It does not appear that perfectly satisfactory results have been obtained with these preparations, but they are praised by many. It is difficult to form a judgment on them without a personal experience. An advance in the material to be employed was made in the introduction of stovaine, which was synthetically prepared by Fourneau. This was markedly less poisonous than cocaine, and also showed good anæsthetising properties. In France it was first employed by Chaput; it was introduced into Germany by Sonnenburg.

Quite recently a considerable improvement has been made in the procedure by the addition of adrenaline to the injection fluid. This substance, which, thanks to vasomotor constrictor power, lengthens the period of resorption, allows of very advantageous modifications in the employment of lumbar anæsthesia.

The technique of lumbar anæsthesia is covered as a whole by that of Quincke's lumbar injection for diagnostic purposes. In puncturing some practice is required as it is not only necessary to get into the spinal canal, but to do it with dexterity and at the right spot.

To bring to mind the topographic anatomy of the region implicated in lumbar anæsthesia, it is above all important to remember that the spinal cord with its *conus terminalis* finds its end somewhere about the level of the arch of the second lumbar vertebra, whilst the dural sac descends to the level of the second sacral vertebra. Over this stretch therefore a needle thrust in will not touch the cord itself under any circumstances, but passes between the bundles of nerves passing almost parallel to each other from above downwards—the cauda equina. These caudal bundles run in two chief cords right and left, leaving a free space in the median line. This space is of special importance for the direction of the needle on puncture.

The bony skeleton, at least under normal conditions, presents no special difficulties in regard to puncture, as the spinous processes do not as in the dorsal vertebræ form a sort of tiled covering but lie more perpendicularly to the spinal axis, and besides this a considerable widening of the space between the arches of the vertebra may be brought about by powerful flexion of the spinal column.

Between the dural sac and the bony spinal canal a more or less well developed cushion of fat lies in which the plexus of veins is embedded. The openings between the vertebral arches and —in adult very strongly developed—the spinous processes are closed by masses of ligaments.

The needle in its course, therefore, passes through the skin, the subcutaneous connective tissue, the muscular structures on the ligaments of the dorsal vertebræ, and passing through these, through the epidural fatty tissue with its venous plexus and the dura into the dural canal where the fibres cauda equina mostly escape the advancing needle.

The spot for puncture is determined, as the counting of the spinous processes is not easy with a well developed fatty covering, most simply by taking the level of the cristæ ilii at their highest point. This line cuts the apex of the fourth lumbar spine.

In performing the puncture it is best to choose the right lateral position on the operating table. This position is much preferable to the sitting one, as sudden fainting of the usually nervously excited patient is not beyond the range of possibility, and moreover it favours a better fixing of the body. The patient's legs are drawn up and the spine is flexed as much as possible. The flexure of spine is increased and fixed by an attendant standing on the ventral side, who encircles both the head and lower extremities in his arms and tries to bring them near together.

In carrying out the puncture the most rigid asepsis is of course necessary. After suitable preparation of the patient, and of the hands of the operator, the puncture is made usually between the third and fourth lumbar vertebræ, thus, therefore, in the third interspace; to puncture lower is not only aimless but it is disadvantageous as regards the effect. The puncture may be made between the second and third arches when a

specially high reaching anæsthesia is desired, or if the puncture in the third interspace is not successful. One half to one cm. on the side of the spinous process, or, in the lateral position of the patient, immediately below it, Quinke's canula is thrust forwards, and a little towards the median line and about 5 to 6 cm. in depth, until you feel, as you generally do plainly, that the needle has passed into a hollow space. The trocar is now withdrawn. If clear cerebrospinal fluid now escapes the canula is in the right place. About 1 ccm. is allowed to flow, and then the syringe partly filled with the medicament is attached to the canula, the plunger of the syringe is then withdrawn until the quantity of cerebrospinal fluid about equals the quantity of the solution in the syringe, and the two fluids are then very slowly injected into the canal. The canula is now removed with a jerk, and the minute wound is covered with gauze and sticking plaster. The patient is now placed on his back and the onset of the anæsthesia awaited. Dönitz has lately advised that the puncture should be made in the middle line, that the needle should penetrate as far as the canal, and pass into it only after the trocar has been withdrawn. This method has the great advantage that the spinal fluid is seen to flow at once, and there is not so much danger of doing mischief by puncturing too deeply.

The whole procedure is only slightly painful, it can be made quite painless by anæsthetising the point of puncture with chloride of ethyl, as the lower layers of tissue have scarcely any sensation. Care must be taken, however, not to puncture the periosteum of the vertebræ, by going too high or too low, or penetrating too deeply.

A number of authorities advise puncture into the middle line immediately below the top of the spinous process, and pushing the needle in perpendicularly. That is, however, as you are accustomed yourself, the puncture laterally is just as safe and easier, inasmuch as the canula has to pass through denser ligaments in the adult. In lateral puncture also the canula has a wider space to play in; again the shape of the spinous process varies, especially in regard to its prolongation downwards, and which sometimes almost covers over the space between the arches. The objection occasionally made to the lateral puncture, that the danger of direction inwards of the needle is uncertain, that it must vary with the thickness of the overlying layers, is in my opinion baseless. The bony opening in question is so wide transversely that the slight difference in the angle could not be of any importance. You can convince yourselves of that by comparing various skeleton vertebræ. In my experience also the technique is easier for the unskilled than median puncture between the spinous processes. On the other hand it cannot be disputed that in puncture in the middle line the needle arrives with more certainty into the space between the two bundles of cord, into which *lege artis* the anæsthetics should be injected.

Regarding the preparation of the instruments one point comes into consideration. Both canula and injection syringe should be washed with plain sterilised water after taking them out of the soda solution, before being used. This is especially indispensable when stovaine is used, as deposits take place with alkalies that lower its activity.

There are a number of conditions that render the carrying out of a puncture difficult. Amongst these is great restlessness, as met with in nervous persons, such are scarcely suitable for lumbar puncture; obesity again that makes it difficult to feel the spinous processes, and that may thicken the parts to be passed through up to 7 to 9 cm. In abnormal ossification of the ligaments puncture may be impossible, and also as in a case observed by the writer lumbar scoliosis; again on the other hand the canula may pass into the spinal canal without any appearance of cerebrospinal fluid and this in spite of all manœuvres. In these cases there is probably an obliteration of the dural canal, either pathological or based on congenital causes.

Independent of technical impossibility it may happen that in spite of the injection of the anæsthetic into the dural sac, owing to some want of power of the patient to react to the drug no action at all, or a much weakened one, takes place. According to some authorities patients with disease of the spine are apt to be refractory.

Apart from these cases one may as a rule look upon failure as caused by faulty technique. Here must be specially remarked, as was done also in the work issuing from Bier's clinique, that one must always see that the flow of cerebrospinal fluid into the syringe is *continuous* after removing the trocar. This continuous flow is a proof that the tip of the canula is in the free space between the two bundles of the cauda equina. If the fluid flows by drops only, the point has very probably got into one of the bundles, and it does not mix properly with the anæsthetic. In such a case one often sees the curious features of a one-sided anæsthesia. In such cases gravity is not the cause, as the anæsthesia may be on the left side when the patient is lying on his right, but an injection not between the two, but into a bundle of nerves does not diffuse itself readily and only the side reached reacts. This feature was noted in the work issuing from Bier's clinique.

It often happens that on removal of the trocar blood comes instead of cerebrospinal fluid; three different causes may account for this: either there has been hæmorrhage into the dural sac, this happens so rarely that it need not be taken into account, then the blood will be dark brown and remain so, and not clot with the cerebrospinal fluid, or a vein may be pricked, when the bright blood will soon clot, and after some waiting the fluid will be clear again, or lastly fresh blood may continue to flow, when it will be that the canula has entered the vein. So long as bloody fluid comes, no injection must be made, but the direction of the needle must be altered, or, better still, a fresh puncture may be made higher up between the second and third or first and second lumbar interspaces.

Regarding the indications for the employment of lumbar anæsthesia it may be observed that it is a method that should come into competition with general anæsthesia, and that even in its present state of development already does so. With this object it is a desideratum that it has no concealed dangers for the patient. The anæsthetics now principally in use, stovaine, novocaine, and alypin that now seems associated with them, have not the frequent serious concomitant effects of cocaine. By the addition of adrenaline the danger of paralysis mounting too high to the medulla is materially diminished; it has been successfully

attempted to prevent this by raising the pelvis after the injection. It is not beyond possibility even to render circular segments anæsthetic without participation of the lower extremities. In any case it is certain that so much has been achieved that without any considerable danger to life the human body can be rendered insensible to operative measure up to the level of the umbilicus and in many cases up to the ensiform cartilage.

Lumbar puncture comes into question in all operations on the lower extremities, on the perineum, on the lower part of the abdomen, for example, internal operations in appendicitis, herniotomy, sectio alta. Gynæcological laparotomies may be performed, but here experience must be gained on account of the general raised position of the pelvis employed. In laparotomies in the lower part of the abdomen we hear keen complaints of pain in the region of the stomach, when the intestines are dragged upon, and when the anæsthesia does not go very high. In operations between the umbilicus and ensiform cartilage the procedure is less certain, but with higher doses, for example stovaine 0·08 grm. with adrenalin, sufficient anæsthesia may be obtained. Moreover, if the anæsthesia is not quite sufficient a few drops of chloroform are enough to gain tolerance.

The great advantage of lumbar anæsthesia, as compared with general is the comparative well-being of patients after operation. As a rule vomiting and nausea are quite absent, as also the general prostration, and patients may even take food when the nature of the operation does not forbid it. The effect on the pulse also is absent, the patient not being stupified breathes more fully and deeply, and the danger of adspiration is avoided.

Lumbar anæsthesia is therefore above all to be recommended in old marantic individuals, when the pulse is poor, in cardiac diseases and especially muscular degeneration of the heart, in disease of the lungs, and, lastly, in drinkers, in whom general anæsthesia is hard to bring about, and withal disagreeable, and very large doses are often required, and the heart perhaps not sound. It is further to be recommended in all affections accompanied with symptoms of ileus, on account of the danger of adspiration, and aided by a semi-narcosis, or still better by a short administration of ether, whilst the intestines are outside. The indication is not so marked in operations in the upper part of the abdomen, the result here is not so certain; gastrectomies have been carried out well, but one has got the impression that local anæsthesia here would have done just as well. The method is sovereign in all operations on the lower extremities, the perineum and pelvis. Here one must not omit to point to the excellent results which have been obtained with lumbar anæsthesia in the repeated bloodless stretching of the nerve in sciatica (Telmann). In spastic conditions of the lower extremities the anæsthesia has not brought about any lasting good results.

Against all this there are a few contra-indications that must be considered if lumbar anæsthesia is not to fall into discredit. The injection should not be made in the case of children under fourteen. One must consider that the youthful organism is more sensitive, and with lumbar anæsthesia a certain amount of intelligence and self-control is required on the part of the patient that can never be looked for in children.

Nervous people also make it very difficult from their great mental excitement. Their moaning and restlessness in spite of the anæsthesia render calm performance of an operation very difficult; here the same conditions are present as in the young. Great caution is required when neuroses, even mild ones, are present—this caution arises not only from the surgical but also the psychiatric experiences of the author. One observes too frequently in such people in connection with even slight operations a very considerable increase in the psychical disturbance which is the more disagreeable as the hypochondriacal ideas coming forward are mainly directed to the part operated on. A patient operated on who, up to the time of the operation, was able to work, showed symptoms of a most severe traumatic neurosis, with complete inability to work, his hypochondriacal idea centred solely on a supposed injury to his spinal cord. If such cases are very rare they require the most urgent consideration. Lumbar anæsthesia is practically an operation affecting the spinal cord or its immediate neighbourhood, and among the public there is a great dread of spinal affections, and, as we know, this fear is the most lively amongst neurasthenics.

Another point deserves mention that does not belong to the series of indications, but rather to the physician's consciousness and his knowledge of the human mind. One should never forget that in contrast to general narcosis, in lumbar anæsthesia there is no shutting out of consciousness and that all major operations and especially mutilating operations cause a psychical shock. If the operation is one likely to cause great mental depression it will be correspondent to humanity to take from the patient the clear consciousness of what is taking place. With this in view it will be well to place an ether inhaler over his face, in which at first a small quantity of ether has been poured. He should be made to inhale deeply, so that the ether shall take a slight effect—a full unconsciousness is not required so long as the attention shall be drawn away from the operation itself, so that the demands of humanity may be satisfied without changing the mode of procedure.

The presence of pyæmia or sepsis is an absolute contra-indication of lumbar anæsthesia. A case related by Sonnenburg on the occasion of his first communication on the subject is very instructive. He lost a patient from ascending purulent meningitis in connection with the puncture in a case of multiple abscesses in appendicitis, and considered the complication to be due to the poison settling on the least resistent spot. This may be explained when one bears in mind that probably an extravasation of blood takes place within the peridural tissues. That this extravasation may be very easily infected where there is a general infection, goes without saying, and it is always to be borne in mind that we are quite powerless in an infection at this spot as compared with the situation in hypodermic injections.

Many authors see in disease existing in the spinal cord a contra-indication, but sufficient evidence on this point has not yet been collected. That spinal cases react easily to lumbar anæsthesia has already been emphasised.

If the contra-indications named are borne in

mind we have, in safe hands, a method of anæsthetizing that is free from danger and which may take its place in all operations from the umbilicus downwards. That this may be so depends in the first instance on the employment of a suitable substitute for cocaine, the three newest of which, besides cocaine and tropacocaine are stovaine, novocaine and alypine, and further in the addition of adrenaline preparations for the purpose of localising the action of the anæsthetic. Efforts to perfect the method are in full flow. Bier and his pupils have to be thanked for a number of technical improvements, and it may be hoped that lumbar anæsthesia may be still further developed.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week's number will be by Sydney Stephenson, M.B.Ed., F.R.C.S., Ophthalmic Surgeon to the Evelina Hospital, the North-Eastern Hospital for Children, and Queen Charlotte's Lying-In Hospital, on "Diseases and Injuries of the Orbit." Lecture delivered in the University of Oxford on July 18th, 1906.*

ORIGINAL PAPERS.

THE METHYLENE BLUE REACTION OF RUSSO IN ENTERIC FEVER.

By J. D. ROLLESTON, M.D.,
Assistant Medical Officer, Grove Hospital.

RUSSO, of Catania, has recently introduced as a substitute for the diazo reaction a watery solution of methylene blue (1 in 1,000), for which he claims the following advantages: simplicity of technique, durability of the solution, and greater diagnostic value. Russo's test is performed by adding four drops of the methylene blue solution to 4 or 5 cc. of urine. (*a*)

Urines which are turbid from excess of urates or phosphates should first be filtered. If the reaction is positive, a uniform mint or emerald green colouration is obtained when the test tube is shaken. If the reaction is negative, the reagent does not change colour, or at most only a light green colouration results. Naturally between the two extremes various shades of colour obtain, as is the case in the diazo reaction.

The present paper is based on observations made on 70 cases admitted to hospital certified to be suffering from enteric fever. In 54 cases this diagnosis was confirmed by clinical evidence and Widal's test. The remaining 16 were found to have other diseases. Of the latter only four presented a positive reaction. One was a case of carcinoma of the stomach and peritoneum, two were cases of infective endocarditis, and one was a case of lobar pneumonia. All died within a few days of admission. A positive diazo reaction was also present in the secases. (*b*) The 12 negative cases were diagnosed respectively as follows:—

Lobar pneumonia	2 cases.
Influenza	2 „
Pleurisy	1 case.
Bronchitis	1 „
Appendicitis	1 „
Cirrhosis of liver	1 „
Cholelithiasis	1 „
Leucocythæmia	1 case
Erythema nodosum	1 „
Cerebral syphilis	1 „

Of the 54 cases of enteric fever, 44 were positive, 10 were negative. With two exceptions, which were cases of moderate severity, all the latter were very mild cases of convalescence when the reaction was first tried. The following shows the two reactions in cases admitted at various stages of the disease:—

	Methylene Blue Reaction.		Diazo Reaction.	
Cases admitted in	Positive.	Negative.	Positive.	Negative.
1st week	7	1	6	2
2nd „	15	4	8	11
3rd „	15	0	10	5
4th „	5	1	1	5
5th „	2	2	0	4
6th „	0	2	0	2
Total	44	10	25	29

The dates at which the reactions became finally negative are shown below, the fatal cases having been excluded.

	Methylene Blue Reaction.	Diazo Reaction.
1st week	0 cases	0 cases.
2nd „	4 „	7 „
3rd „	11 „	11 „
4th „	12 „	2 „
5th „ and later	11 „	0 „
Total	38	20

It is evident from the above figures that the methylene blue reaction is more constant and more persistent in enteric fever than the diazo reaction. That disappearance of Russo's reaction coincides more closely with the commencement of lysis, and that, therefore, *cæteris paribus*, a negative methylene blue reaction is a surer sign of convalescence than a negative diazo reaction, is shown by the fact that in all the 38 cases in which Russo's test was employed the two events occurred in the same week; whereas in the 20 cases in which the diazo reaction was concurrently used, in 14 the two events occurred in the same week, and in six lysis did not commence till the week following the disappearance of the reaction.

The two reactions resemble one another, in that before disappearing entirely there is usually a diminution in their intensity, the successive grades in the methylene blue reaction being conveniently designated by the letters M. B. R. +, M. B. R.—, M. B. R.— —, which correspond with shades of colour varying from a deep green in the first case to a light green in the second, and a decided blue in the third. Both reactions before becoming finally negative may be occasionally positive. Another point of resemblance between the two reactions is seen in their occasional disappearance in spite of aggravation of the general condition. This indicates the supervention of a secondary infection or impermeability of the kidneys to the colouring matter. Thus in three cases which, though the two reactions had become negative, the patient was obviously worse, one died of lobar pneumonia, one of perforative peritonitis, and one of hæmorrhage.

On occurrence of pyrexia in convalescence from enteric fever, in the absence of enlargement

(*a*) Metropolitan Asylums Board Annual Report, 1905.
(*b*) The occasional presence of the diazo reaction in these diseases is noted by Rivier (*loc. cit.*).

of the spleen or of a fresh outbreak of rose spots or other obvious physical signs, determination of the nature of such pyrexia may be a matter of no little difficulty. The diazo reaction is often a valuable guide, but in some cases of definite relapse it may fail to be positive. In such cases Russo's reaction is a more delicate test, since it often becomes positive again, while the diazo reaction remains negative. Thus in ten cases of relapse the diazo reaction which had previously become negative became positive again in three cases only; while Russo's reaction became positive in seven cases. It is noteworthy that those relapses in which the diazo reaction became positive again were more severe than those in which Russo's reaction alone was positive; while those in which both tests remained negative, the pyrexia was of a shorter duration still.

As with the diazo reaction a positive result may be obtained at a very early stage of the disease before Widal's test gives definite results. In one of my cases a positive methylene blue reaction appeared as early as the second day, though the diazo reaction in the same case did not become positive till the fifth.

Contrary to what is stated by Russo, I have found the methylene blue reaction positive in several cases of scarlet fever, lobar and broncho-pneumonia. I have also found it occasionally, though exceptionally, present in diphtheria and serum eruptions. Like the diazo reaction it is almost always present in measles. It was positive in 18 out of 20 cases in which I was employed.

Conclusions.—(1) Russo's reaction persists longer in enteric fever than the diazo reaction.

(2) The disappearance of Russo's reaction corresponds more closely with lysis than does the disappearance of the diazo reaction.

(3) In relapses, a positive Russo's reaction is more frequently found than a positive diazo reaction.

(4) The diagnostic value of Russo's reaction is similar but not superior to the diazo reaction.

References—1 Loeper et Oppenheim. *Gazette des Hopitaux.* May 2, 1901.
2 Rivier. These de Paris. 1898.
3 Rolleston, J. D. *Lancet.* February 4, 1905.
4 *Riforma Medica.* May 13, 1905.

PERSISTENT UNILATERAL HEADACHE DUE TO NÆVOID CHANGES IN THE ANTERIOR EXTREMITY OF THE MIDDLE TURBINAL BONE.

By WYATT WINGRAVE, M.D.,

Pathologist (lately Physician) to the Central London Throat and Ear Hospital.

THE pathogeny of severe focal headache is somewhat speculative, and this case is recorded partly for its instructive and definite morbid anatomy, but also because it affords an explanation for the occasional want of success in treating the middle turbinal body by cautery and local depletory measures for symptoms attributed to hypertrophy of that structure.

The patient, a healthy looking male, æt. 38, sought relief for severe and persistent frontal pain of three months' duration, dating from an attack of influenza. The pain was referred to the left supra-orbital and frontal regions extending to the vertex and occasionally to the corresponding eye. It varied in severity, but never left him, and was at times so acute as to interfere with his clerical duties and to cause him much anxiety. There were frequent attacks of coryza, which generally afforded partial relief, and he had been treated for migraine and hay asthma.

He was an enthusiastic athlete, of regular habits, temperate in tobacco and alcohol, but thought that he was gouty and had a tendency to piles. His only illness of any importance was influenza, from which he had suffered several attacks, the last one leaving a persistent nasal catarrh which had, however, nearly disappeared, although the pain had not diminished in spite of treatment.

Upon examination the right nostril was found to be quite free, but the left breathway was distinctly less in volume, due in part to a slight septal deviation, but chiefly to a marked hypertrophy of the left middle turbinal, which completely blocked the meatus. Probing was very painful, but yielded no evidence of bone lesion, and there was no sign of pus. Under cocaine the turbinal became pale, but diminished only slightly in size.

On transilluminating, the frontal and maxillary sinuses were found to be perfectly clear and symmetrical; still it was felt that the unilateral pain, together with the history and local signs pointed to some sinusal trouble probably due to drainage obstruction.

Local sedatives, general depletion, and bromides for a week affording no relief, the anterior end of the middle turbinal body was removed under alypin and adrenalin chloride by means of a Krause's fine wire snare which cut through the bone with ease. This was followed by free hæmorrhage lasting about fifteen minutes, but the pain gradually ceased and in the course of half an hour he left for home perfectly comfortable. No discharge of any kind beyond bleeding attended or followed the operation, and subsequent examination revealed no evidence of sinusal trouble. He made a rapid and complete recovery, six months later reporting that he had experienced no return of pain and enjoyed complete freedom from any "running" from the nose.

The part removed was about the size of a large haricot bean measuring 15 by 12 mm. On microscopic examination the mucous membrane appeared normal, but the bone cancelli were found to contain very thin vessels fully distended with blood and pressing on the walls. There was no evidence of lymphocyte infiltration nor any osteoplastic activity such as is usually found in inflammatory sinusitis involving the bone. The walls of the distended vessels were very thin, consisting only of epithelioid cells, in striking contrast with the arteries which as seen in the adjacent cancelli were quite normal. The condition which is strongly suggestive of a nævoid state, differs entirely from cavernous distension of the erectile tissue so common in the posterior end of the inferior turbinal, a state which involves the mucous membrane only and not the bone (*a*). Part of the bone was pneumatic and lined with normal mucous membrane, continuous with that of the ethmoid cells, a condition often found in hypertrophy of this part, and somewhat loosely described as "cystic turbinal."

(*a*) "Turbinal Varix," *Lancet*, June, 1894.

Although a moderate degree of congestion both periosteal and endosteal is often present in sections of removed middle turbinals, in this case it was exceptional, and together with the coincidental disappearance of symptoms on its removal, it may reasonably be interpreted as possessing a causal relationship. The morbid condition may be regarded as a passive nævoid process involving the spongy bone and bearing no resemblance to any inflammatory process such as rarefying osteitis, necrosing ethmoiditis, or suppurative sinusitis.

The association of the middle turbinal body with headache and many reflex phenomena is familiar to all rhinologists, likewise its anatomical relation to the hiatus semilunaris, which plays so important a role in drainage and ventilation of the accessory sinuses of the nose, but in the former connection, treatment has for the most part been restricted to cautery and other applications to its mucous membrane only; removal of the anterior end including the subjacent bone is more usually resorted to as part of the radical treatment of the sinuses, or, at all events, an essential preliminary.

The morbid anatomy of the case illustrates the inexpediency of persisting in the treatment of mucous membrane only, when it fails to afford relief at once. The fact of its having already failed in this case influenced not a little the adoption of the more radical course of dealing with the bony structure.

The operation is so extremely simple and quick that there is no necessity for a major anæsthetic, and punch, forceps, scissors, &c., are quite superfluous, for when the anterior end of the middle turbinal is sufficiently enlarged to require removal, a fine wire snare pushed well upwards and backwards will readily engage it and when gradually tightened will cut clean through both bone and mucous membrane. Care must be taken (1) to avoid simply stripping off the mucous membrane, which may happen if the turbinal be not properly engaged, and the snare not sufficiently pressed upwards; also (2) not to exert any dragging, twisting, or tearing force, since in patients over æt. 40, the ethmoid bone is extremely brittle and "biscuit"-like owing to senile osteoporotic changes in the bone. This caution applies equally to the removal of polypi in those of advanced years.

Note.—Since writing this report a paper has been read by Dr. Smurthwaite on "Headache Connected with Enlarged Middle Turbinal" Similar treatment is advised, but the pathology is different.—W.W.

PROPOSED STERILIZATION OF CERTAIN MENTAL DEGENERATES.*

By ROBERT R. RENTOUL, M.D.,
Late Member of the General Medical Council.

My chief reason for bringing forward this proposal in 1903 was that I failed to see any other plan by which we could prevent the present large total of mental degenerates from handing on their degeneracy to their offspring. According to the English Lunacy Commissioners' Report, there were, on January 1st, 1905, 119,829 officially certified insane, or 1 in every 285 of the population was insane. In 1896, 1 in 319 was insane. On the same day, there were in Scotland 17,241 certified insane, and in Ireland 22,966. In Ireland there was 1 insane person to 178 of the population; in 1851, 1 in 657. During the last fifty years the Irish population *decreased* by 31·9 per cent., while the insane rate increased by 198 per cent. A study of the statistics presented by the 1901 census of the United Kingdom shows that there were 484,507 mental degenerates, or 1 in 85 of the population. I think a more accurate proportion would be 1 in 50.

The studies of Down, Beach, Tuke, Shuttleworth, Barr, and others show that there is a deeper depth than that of ordinary lunacy. They have called attention—not to the idiot, imbecile and lunatic, but to the "feeble minded," "mentally backward," and "defective" child. It is calculated that in England at least 1 per 1,000 of the population between the ages of 5 and 14 is feeble-minded, that is 88,346. Others have placed the total at 105,000, of whom only one-third could be made self-supporting.

I would ask you to emphasise the fact that these "defective" persons are the most dangerous citizens, and especially from the procreation standpoint. Who of us would, however, wish to be joined in marriage to such a defective, or to see our children marry? This is the test. These, and the many "borderland" cases—and amongst these I would include the markedly neurotic—drive one to the conclusion that we are compelled to adopt my proposal of sterilization. One cannot drive home with too much energy the fact that there is a wide difference between the medical and legal views as to what constitutes degeneracy. No doubt, those who are not *legally* insane, but in whom insanity is latent and only requires some shock or stimulant to bring it to the surface, do beget degenerate children. But the legal mind ignores this fact, and fails to recognise that national sanity and national well-being are of more importance than is the "liberty of the subject," when considered with the question of procreation by insane persons. With the lawyer "liberty of the subject" is here synonymous with liberty to breed lunatics and to curse the offspring with indelible blemishes.

That insanity is on the increase few honest thinkers will question. The English Lunacy Commissioners, in their Annual Report, say "No sustained advance has taken place in the average recovery rate in the last thirty years." Dr. F. J. Smith says "Anatomical research and neurological inferences tend to show that recovery from lunacy is not, and cannot be, complete." The English Commissioners, in their Report, state that the number of insane under their supervision has for some time past been steadily increasing at a greater rate than the growth of the population. Thus, the rate of increase of the population during 1891 to 1901 was 12·2 per cent., while the insane community, known to the Commissioners, increased by 24·4 per cent. The Scottish Commissioners report that since 1858 the number of insane under their care has increased by 190 per cent., and the population by only 52 per cent.

I do not propose to remove the testes, or ovaries, and I object to the terms "mutilation," "castration," and "asexualization," as I do not propose to destroy either the primary or the secondary sexual characters of either male or female, even when these are insane or mutilated by the gross errors of their progenitors. In the female I propose that part of the fallopian tubes be excised and ligatured—a simple operation. In the male degenerate I have proposed two operations. In one of these part of the vasa deferentia shall be excised and ligatured (vasectomy); in the other, a portion of the spermatic chords should be excised and ligatured (spermectomy). My reasons for so proposing are: Experiments upon animals have shown that when the vasa deferentia have been divided and ligatured, the testes do not atrophy, and there is sexual power, but no power to impregnate. This in the little operation which should be undertaken is what I term voluntary sterilization. In the other operation—spermectomy—the testes do wither, and there is no sexual desire, no sexual power, and no power to impregnate. This operation would come under any division of compulsory sterilization, and would apply

*Abstract of paper read before the section of Psychology at the Annual Meeting of the British Medical Association, at Toronto, August, 1906.

to lunatics, epileptics, idiots, confirmed criminals, and inebriates, habitual vagrants, and those mentioned in Table F. Either operation should be undertaken at as early an age as is possible.

No surgeon should be allowed to operate without the written permission of the Lunacy Commissioners, not should any surgeons operate unless specially licensed by the Commissioners. A full annual report should be laid before Parliament. If any person operate without special authority and without the written consent of patient's parents or guardian, or if any person use a sterilized person for unlawful purpose, or if any sterilized person marry or join in marriage any sterilized person to any non-sterilized person without first notifying the fact to the latter, then a penalty of 15 years' penal servitude should be imposed for each offence. At present, in England *all* surgical operations are legally an "assault," and so consent must usually be obtained.

I would here call attention to the experiments of Albers-Schonberg, which show that the action of the X-rays so alter the texture of the testes of rabbits and guinea-pigs that, although these animals have sexual desire and sexual power, they have no power to impregnate. Such action would do away with the necessity of a surgical operation.

Dr. F. J. Smith partly supports my proposal. He suggests that where a woman becomes insane after confinement and kills her child she should be sterilized. But why wait until she kills her child? Also, that when insanity is due to alcohol or drugs, and the *habitue* commits a murder, such person should be sterilized. But, again, I ask, why wait until a sane person has been murdered, or until the degenerate has, perhaps, impregnated several other females? Dr. Barnardo—one who fully understood the degenerate side of life—wrote to me as follows: "Some step will have to be taken in the near future if we are to protect the nation from large additions of the most enfeebled, vicious, and degenerate type." He advocated enforced segregation, and sterilization for the few. Mr. Wells has said: "It is in the sterilization of failures and not in the selection of successes for breeding, that the possibility of improvement of the human stock lies." Dr. Lydson, in his work, "Diseases of Society," strongly supports "asexualisation." Dr. Barr, in his book, "Mental Defectives," gives strong support. In 1905 the Legislature of the State of Pennsylvania adopted a Bill legalising sterilization, but, unfortunately, the Governor refused to signet. Dr. Craddock, Medical Superintendent of the County of Gloucester Asylum (England), in his last Annual Report, says: "The sooner this day arrives (for legalising sterilization), the better for the welfare of the nation." It is encouraging further to state that many of those who gave evidence before the Royal Commission on the Feeble-minded—now sitting in London, and to which I presented evidence—have supported this proposal to sterilize degenerates. Correspondence from Canada, America and Australia show me that many—who did not wish to take a place in the fighting line—are in favour of a well-guarded system of sterilization. In an old country like England the pioneer thinker runs the grave risk of being denounced as a "crank," or a "disturber of the minds of the people." It is for this reason I have taken the opportunity of laying my proposal before the receptive minds of Canada and America. When I say that no less than ten—apparently respectable—firms refused to publish my monograph on the "Proposed Sterilization of Certain Degenerates," and severely lectured me for my audacity you can understand in a small degree the risks run by advanced thinkers.

WHAT ARE THE ALTERNATIVES TO STERILIZATION?

The *first* is the usual one of *laissez faire*—leave things alone to right themselves: a degenerate proposal—the product of degenerate minds.

The *second* is the murder of degenerates. This is another degenerate proposal.

The *third* alternative is, the supplying of degenerates with the means to prevent conception. Is it likely that lunatics, idiots, epileptics, confirmed criminals, habitual inebriates, and footpads would use such methods?

The *fourth* alternative is life-long incarceration. Such a plan would not effect a real cure, as, judging from existing conditions, many would be discharged as "cured" who were not cured. The Lunacy Commissioners always seem anxious to release the insane at the earliest possible moment. Their statistics relating to those who "recover" are a public laughing stock, and constitute a grave public scandal. Further, few physicians, in putting forward life-long incarceration, seem to have studied the taxpayer. Table C shows that in one year only over £18,000,000 were expended in the upkeep of degenerates in the United Kingdom, and, if *all* degenerates were immured, I have calculated that at least £50,000,000 annually would be required. Such a sum would cause a public revolt of the already over-burdened taxpayers.

The *fifth* alternative to sterilization is the *encouraging of suicide*. The number of suicides and of attempts at suicide are, fortunately, on the increase, and further, the attempted suicide is showing a greater tendency to murder his children before ending his or her own life. About 25 per cent. of those admitted into asylums in England have a strong suicidal desire. In the United Kingdom during 1902 there were 3,829 suicides. If this number has occurred during the last twenty years this would give a total of 76,580. But the statistics are grossly misleading, as they do not include attempted suicide, or the 6,205 who died from "drowning," (?) poison," (?) "suffocation," (?) and "not certified" by physician or coroner. I would estimate the number of suicides in the United Kingdom at 13,000 yearly. The total number, however, will never be known until we have compulsory notification to the Lunacy Commissioners of all suicides and attempted suicide. An increase of suicide cannot however, be looked to as a means of eradicating degenerates; for if to-day every insane person suicided, and we refused to attack the causes of degeneracy, there would still be as great a number of degenerates as now existing.

The *sixth* alternative to sterilization is forced abortion Criminal abortion is now very prevalent among Christian communities, and it would be dangerous to extend its scope. I regret to find that Clouston, in his work "Mental Diseases," recommends that abortion be resorted to when marked insanity comes on during pregnancy. My proposal is to kill neither the mothers nor the infants, but to make it impossible for the woman to conceive. I ask, which is the more humane proposal?

The *seventh* alternative is, making it illegal for anyone to marry until they produce a certificate of good mental and physical health. Although I have put forward this proposal as necessary, it would not meet the present conditions unless it were associated with sterilisation. We must recollect that a great many infants are begotten and born out of wedlock. During the years 1891 to 1902, no less than 425,958 children were registered in England as illegitimate births.

The *eighth*, and last, alternative to sterilisation is the plan adopted by some American States, where it is illegal for certain degenerates to marry or to be joined in marriage by a cleric or registrar. I have tried to find out if any convictions have taken place under these laws, and have failed to find any record. How could we? Is not the insane person free of punishment for his or her actions? The law of non-responsibility comes in and applies to lunatics, idiots, imbeciles, feeble-minded, in fact, to all likely to beget degenerate offsprings, and if we refuse such persons marriage they will live in concubinage or prostitution.

It is, no doubt, an appalling and humiliating fact, as shown by the 1901 Census returns that, on one day in the United Kingdom, there were 60,721 idiots, imbeciles, and feeble-minded, and of the number 18,900 were married or widowed. Here we have—

under clerical blessing—a veritable manufactory for degenerates. The same Census also shows that of 117,274 lunatics, 46,800 were married or widowed.

We must recollect that it is not only the *married* degenerates who beget. Dr. Craddock has referred to the disgusting case where a half-idiot left the asylum to be married, and who gave birth to nine idiot children in a few years. Mr. Bagnall, Local Government Board Inspector, has called attention to a woeful state of affairs where, in Yorkshire, five unmarried and feeble-minded females had been confined of no less than fifteen children.

To what goal will a policy of inaction and drift lead us? The legacy of degeneracy which has been handed down to us, and which we are wilfully preparing for the next generation, is too vast, too deep, and too far-reaching to be met by mere platitudes and mere palliations. If we adopt the cowardly idea that the existing conditions are beyond our control, and that all that can be done has been done, we recognise that anyone who brings forward a new proposal deserves an attentive and honest hearing. Fortunately, surgery comes to our aid. At present the *diseased* ovaries, tubes, uteri, and testes are removed when these organs are diseased. Last year over 2,000 women were so sterilized in the hospitals of the United Kingdom. No one objects. Next, surgery has taken a second step forward by removing *healthy* ovaries because some neighbouring organ is diseased, because of deformed pelvis, cæsarian section, ovarian hernia, mollities ossium, and enlarged prostate. Here again no one objects. I now ask that surgery take a third and chief step forward, and that, as we agree to operate for physical diseases, we shall agree to perform a trivial operation which will tend to greatly lessen and prevent mental degeneracy. Breeding from degenerates must fail. It is Carlyle who cheers all pioneers of thought by saying, "The strong thing is the just thing."

For the above and many other reasons I would earnestly ask all sociologists, and all those engaged in the care and prevention of mental degeneracy, to give a patient consideration to the proposal now laid before you.

THE OUT-PATIENTS' ROOM.

ROYAL FREE HOSPITAL.

Tumour of Testicle.—Amongst Mr. Cunning's out-patients was a boy, æt. 16, who complained of a swelling in the scrotum, which had been coming on for six months. He had taken no notice of it until a week ago, when he received a knock on the part, since when it had been slightly painful. On examination, the scrotum appeared the size and shape of a turkey's egg; the swelling was solid, hard, and painless, and seemed to be confined to the epididymis; there was no involvement of the skin nor was there any thickening of the vas deferens. *Per rectum*, no thickening of the vesiculæ seminales could be felt. With regard to the diagnosis of this case, Mr. Cunning pointed out that with reference to solid tumours of the scrotum, tuberculous disease, gumma, and new growth had to be thought of. To take syphilis first, the present tumour was one of the epididymis, whereas syphilis almost invariably affects the testis, and as there was complete absence of any other signs of syphilis the question of gumma might be left out of account in this case. Next, as to tuberculous disease: although it always affects the epididymis first, yet in a tuberculous tumour of this size the surgeon would expect to find signs which were absent in this case, namely, involvement of the skin, thickening of the vas deferens, and perhaps of the vesiculæ seminales; therefore tuberculous disease might be excluded. He was therefore left with the diagnosis of new growth. Of new growths of the testicle, there were, he said, two common ones, fibro-cystic disease and sarcoma, the former being an innocent tumour and the latter, of course, malignant. It was, he pointed out, very difficult to decide which of the two existed in this boy; he was, however, rather inclined to think the growth was sarcomatous, because it was uniformly solid, whereas in fibro-cystic disease one would expect to find soft spots. The age, however, of the boy was rather in favour of an innocent growth, although one knows how very unreliable was a question of age in the diagnosis of malignant disease. One other point was the absence of thickening of the vas deferens, which, of course, meant that it was an innocent growth or possibly an early malignant one. It was well known, too, he remarked, that the glands are involved quite early in malignant growth of the testicle, and their absence in this case was a point in the patient's favour. All points considered, he was inclined to regard it as a case of sarcoma. The treatment, whether the disease were fibro-cystic or sarcomatous, would be removal of the affected testicle.

OPERATING THEATRES.

ROYAL FREE HOSPITAL.

Perinæal Wound of the Bladder.—Mr. Willmott Evans operated on a young man, æt. 18, who had been wounded in the perinæum. The patient gave a history that he had been carrying a sack containing many pieces and splinters of wood, when he suddenly fell into a sitting position on the sack, and it was found that he had received a wound in the perinæum, a splinter of wood having passed through his clothes and inflicted the wound. At first he merely felt a little pain, but towards the evening of the same day, as the discomfort increased, he came to the hospital and was admitted. On admission, a small wound was discovered to the left and a little behind the anus, into which a probe was found to enter about an inch and a half. Simple dressing was applied, and he was kept in bed. The next day it was seen that he had partial incontinence of fæces, and this symptom continued to increase for two or three days. On the second day, after admission, a little blood-stained fluid, which was apparently urine, escaped from the perinæal wound, and the temperature reached 102. Mr. Evans then saw the case for the first time, and decided on immediate operation. The patient, having been anæsthetised, was placed in the lithotomy position, and the wound in the perinæum enlarged with a scalpel; it was then seen that the deeper portion of the original wound was more extensive than had been at first recognised. A probe was now found to pass upwards and forwards for about five inches, and urine escaped. A catheter was introduced per urethram, a rubber drainage tube passed through the perinæal wound into the bladder, and several quarts of hot boracic solution were sent through the bladder by way of the catheter and out through the drainage tube. The catheter was then removed, but the tube left in position, being secured by a stitch to the edge of the wound. The patient was then returned to bed. Mr. Evans said it was clear that the splinter of wood had passed up by the side of the rectum and perforated the posterior wall of the bladder, probably through the trigonum. Possibly, he thought, the mucous membrane of the bladder had only been partly perforated for no urine had escaped through the wound for the first forty-eight hours, then the remaining thickness of the mucous membrane had sloughed or otherwise given way, so the urine escaped through the opening. The rise of temperature showed, he considered, that some septic absorption had occurred, but in all probability this would cease now the drainage was complete and thorough. The incontinence of fæces, he pointed out, was not due to any perforation of the rectum, but it

might possibly be explained by a tear of some of the outer muscular fibres of the bowel. The chief object of the operation, he remarked, was to prevent extravasation of urine into the pelvis, whether above or below the recto-vesical fascia. The former was much the more dangerous of the two, but even the latter might lead to much fever and cellulitis.

With regard to the further progress of the case: the temperature fell to normal within thirty-six hours; for a day or two most of the urine escaped through the drainage tube, but after that a gradually increasing quantity came through the urethra. Twice a day a quantity of hot boracic solution was passed through the urethra and out by the drainage tube; the latter was shortened by one inch on the third day, and on the fifth day the urine was discharged wholly by the urethra. The drain was then removed. A day or two later some urine, however, was again discharged by the perinæal wound, but this soon diminished. Within a few days of the operation the incontinence of fæces began to lessen in extent, and by the end of the first week it had almost ceased.

KING'S COLLEGE HOSPITAL.

DETECTION OF STONE IN THE BLADDER.—SUPRA-PUBIC CYSTOTOMY. REMOVAL OF TWO CALCULI AND OF ENLARGED PROSTATE.—MR. BOYCE BARROW operated on a man, æt. 76, who had been admitted with very frequent and painful micturition. Mr. Barrow pointed out that this case was of interest on account of the difficulty in detecting the calculi in the bladder. He had failed to discover the stones with the ordinary sound and the X-rays did not show them; even examination under an anæsthetic with an ordinary sound did not demonstrate the presence of a stone. Mr. Barrow therefore decided to try the evacuator, the powerful suction of which drew a stone against the instrument and a distinct click could be heard. Supra-pubic cystotomy was then performed forthwith. No difficulty was experienced in opening the bladder and two stones were found lying imbedded in a pouch hidden by an enlarged prostate. These were removed, and the patient's condition being pronounced satisfactory by the anæsthetist, Mr. Barrow decided to proceed to remove the prostate then and there. The prostate was very large, but its removal was rapidly effected; the bleeding was treated by two or three plugs saturated with adrenaline being introduced allowed to remain *in situ* for a few minutes, and then replaced by others. These were then taken away and the whole of the bladder washed out with boracic acid; a rubber catheter was introduced by the urethra, and tied in; a rubber tube was fixed in the supra-pubic opening. Mr. Barrow remarked that he had seen many instances of the value of the evacuator in discovering stones. The idea, he said, had first occurred to him many years ago, that inasmuch as the evacuator was so useful to show that a small fragment of stone remained in the bladder after lithotrity, it must be a very reliable means of finding a calculus at any time, this applying more especially to the discovery of a small stone. In an ordinary way, Mr. Barrow said, he would not advocate the removal of the prostate at the same time as the stones in the bladder of a man of this age, but, although the anæsthetic had been administered first for the examination of the bladder, and detection of the stones by the sound and evacuator, and had been prolonged for the supra-pubic cystotomy, the patient's condition appeared so good notwithstanding this extended administration that in this case Mr. Barrow felt justified in proceeding to the prostatic operation, and, the condition of the bladder being sufficiently satisfactory, there was, he thought, a better prospect for the patient after the removal of this formidable obstruction to the urine. Anæsthesia, he pointed out, had been continued for an hour and a half, yet the patient was taken from the theatre in quite a satisfactory state, and that he attributed to the discretion exercised by the anæsthetist in only keeping the man very lightly under the influence of the anæsthetic except at the more important and painful stages of the operation. Therefore, he said, an anæsthetic might be administered quite safely for a very long time providing full anæthesia was only produced at the essential periods. That showed, he considered, the value of an anæsthetist who appreciated the importance of the stages of an operation and administered the anæsthetic accordingly, and this, he said, had been admirably carried out by Dr. Flux.

It is satisfactory to state that the patient left the hospital four weeks after the operation and three months later presented himself to report his highly gratifying condition, the urine being perfectly clear, there being no increased frequency of micturition and his control over his bladder being perfect.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Sept. 16th, 1906.

A SURE SIGN OF DEATH.

THE fear of being buried alive haunts very many persons, and it cannot be wondered at, as more than once cases of premature burials have come to light, while numerous are those where the supposed dead person "came to life" in the coffin just before being carried out. It is not surprising consequently that medical men have made for many years a study of the important question of complete suspension of organic life. How often have medical attendants been appealed to by the relatives or friends of the diseased in cases of sudden death as to the reality of the misfortune fallen upon them, and it requires all the tact possible of the doctor to raise all doubt on the fact.

In countries like England, where the body is kept for several days, premature burial is almost impossible; but in France and other southern countries, where the burial takes place as a rule on the third day, if not on the second, such a deplorable error is unfortunately possible. To find a sure and infallible sign of death was not easy. Some time ago someone affirmed that the burn sign was about as near it as was possible. Place a lighted candle or match beneath the fore-arm of the dead person and sufficiently near as to produce a burn of the second degree.

If the man had still a spark of life in him, the skin would raise like a blister, or, rather, like an ordinary burn, and fill with serosity in a few minutes. If, on the other hand, the man was dead, no blister would take place immediately, but later on the part would swell under the influence of gases, and burst with a crackling noise. The absence of serosity was consequently considered as a sure sign of death. The experiment was tried, and pages of medical journals were filled with different views on the efficiency of it, and finally its infallibility was rejected.

Naturally putrefaction is an authentic sign, but it is frequently inconvenient, if not dangerous, to wait for it.

Dr. Icard, of Marseilles, has come forward with a sign as sure as putrefaction itself. He found it in the sulphurous gases which precede the external signs of putrefaction, and if his experiments are found in all cases correct, he will have conferred a great benefit on humanity. He argues that sulphurous gases are found in great abundance in the lungs after death, and escape through the nose. It suffices, consequently, to have

positive proof of the reality of death, to introduce into one of the nasal fossæ, or to place under the nose, a small piece of paper (ordinary writing paper) upon which is scribbled something or anything, with a solution of acetate of lead. The writing is naturally invisible, but when brought into contact with the sulphur gases it becomes sufficiently black to be read by all, whereas at the moment of being applied, the paper was absolutely white.

It is the dead man himself who says, "I am dead," and he furnishes the proof of the truth he affirms.

The hydrosulphurous reaction takes place in all cases of absolute death and never in case of apparent death; it furnishes consequently an infallible sign, as certain as putrefaction itself, and this sign can be obtained by anyone.

The reaction shows itself generally at the end of twelve hours, but sometimes it may be delayed to twenty-four hours; in any case, it precedes considerably the dangerous state of putrefaction.

Treatment of Hæmatemesis.

Frequently gastric hæmorrhage is so abundant that the classical absolute diet is not sufficient. Injections of ergotine produce but temporary effect, while absorbent powders possess only a neutralising action. Ice to the epigastrium and ice taken is good practice, but Dr. Œttinger, of the Broussais Hospital, affirms to have had more success from a preparation of gelatine, given by the mouth, than from adrenaline or chloride of calcium.

Gelatine	1 ounce.
Sugar	1 ounce.
Syrup of lemons	1 ounce.
Water	6 ounces.

This jelly has an agreeable taste, and is taken by teaspoonsful.

Besides this treatment, he gives two or three injections of serum during the day (six ounces each time), and ice.

GERMANY.

Berlin, Sept. 16th, 1906.

The Pathogenesis of Multiple Abscesses in Infancy.

This subject has been recently discussed in a paper by Dr. Lewandowsky, in the *Arch. f. Dermat. u. Syph.* 80–2. These so-called multiple abscesses differ from the furuncular of the adult in that there is less tension and in the absence of inflammatory symptoms and by their tendency to free suppuration without any necrotic core. Escherich by developing by cultivation both the staphylococcus pyogenes albus and aureus out of them had shown that their ætiology was that of ordinary furuncular. From his own investigations Lougard has declared a hæmatogenous origin of these improbable, the histology pointing more to an internal origin than an infection from without. Internal diseases that lead to atrophy and cachexia lead to a special disposition for them. One of the chief ports of entry to the excitors of the disease are the openings of the sweat glands, a view that has been combated by Unna, according to whose observations the deep abscesses of infants as well as the boils of adults are caused by the entrance of staphylococci by the route of the hair follicles, between the hair and the external root-sheath.

The author lately had the opportunity of examining the bodies of three extremely atrophic infants with multiple abscesses. In all three cases along with the abscesses, there were in greater or less numbers small pustules with white contents and surrounded by a red margin. In size they varied from that of a pin-point to a linseed. The staphylococcus pyogenes aureus was present in both pustules and abscesses. Histological examination showed that the origin of the disease from within, *i.e.*, through transport of the staphylococci into the skin through the blood, could be excluded. It further showed that the excretion of disease found its way principally through openings of the sweat glands; he was able to follow the invasion in almost all its stages. First of all the parasites collected in the terminal portion of the exit passages, so as to completely block them up. An inflammatory reaction was not a constant sequence of this, but frequently there was intra-epithelial suppuration around the sweat glands which could be distinguished from folliculitis of the hair follicles as periporitis. It appeared clinically in the form of the above-named pustules, that stood in the same relation to the sweat-glands as impetigo Bockhart to the hair follicles. They are distinguished from these microscopically by the lesser vaulting of the pustules, the absence of central hairs, and the whiter appearance from the vesicles of impetigo contagiosa or vulgaris in that their contents are never purely serous and that they show no tendency to the characteristic formation of scabs. Periporitis plays in the pathogenesis of the abscesses of infants the same role that folliculitis impetigo does in the causation of the furuncular of adults. As, however, on the one hand numerous pustules dry up without an abscess coming forward, so on the other hand abscesses may form without a preliminary pustulation when the staphylococci penetrate into the depths of the sweat passages without causing changes of the surface. Why the mode of invasion on the infant skin is different from what it is in the adult cannot at present be explained.

Therapeutically the knowledge of this mode of invasion should lead to attempts to disinfect the skin and also by causing sweating to free the organism from staphylococci so long as the condition of the child leads to the expectation of fresh outbreaks.

Bier's Cupping Glasses in the Treatment of Tuberculous Fistulæ.

The *Zentralbl. f. Chu.* 28, 1906, has a paper on this subject by Dr. Gangele. For some time past the author has treated all cases of tuberculous fistulæ of joints that had already undergone the usual general treatment by means of india-rubber bandages and cupping glasses. In old fistulæ that had already existed for years, in which a single track the size of a knitting needle led to the disease centre, he observed a clearing up of the fistula, but never a complete closure of it. In more recent cases the track closed up quickly from within. He obtained specially good results, in the case of a weakly boy, æt. 6, who had three fistulæ from tuberculous hip joint disease. He placed the glasses on each fistulous opening twice a day for threequarters of an hour each time; intervals of three-minute suction alternating with five-minute pauses. If any secretion formed under the tender new skin forming, a small opening was made and sucked carefully; in this way perfect recovery rapidly took place.

At the Psychiatrischer Verein, Hr. Hubner showed cases of

Syphilis-Tabes Paralysis.

A patient with absence of knee jerk and rigidity of pupil had for a year found herself in a state of the greatest excitement when she got bilateral paralysis of the radial and peroneus nerves. The former got better quickly, but the latter continued to her death. There was diminution of electrical excitability and slow twitchings. She got six series of attacks, succumbing in the course of the last one. *Post-mortem*: There were found chronic meningo-cephalitis, atrophy of the frontal region, grey degeneration of the posterior columns, degeneration of the peronei, and in the region supplied by the radial nerve.

The second case was that of a woman with reflex rigidity of pupil, girdle sensation, absence of knee jerk, lightening pains and gastric crises. Anatomically along with pronounced tabes there was a gumma in the right middle fossa.

The third case was a man æt. 49, who had typical paralysis and died after three months in hospital, succumbing to the first attack. The left cerebral pia mater was strongly adherent, the attacked portion of brain having numerous blood vessels. There was a similar spot at the part where the lateral and occipital lobes joined and on the right and on the lateral lobe itself. Its gummatous character was proved. Further

there was degeneration of the lateral column in the lumbar region. It still remains to be determined whether the spirochæte pallida was present.

AUSTRIA.

Vienna, Sept. 16th, 1906.

PATHOGENESIS OF TUBERCLE.

WELEMINSKY raised the question of Tuberculosis at the Prague "Verein," in its supposed form of intection. This is always a fruitful subject for discussion, and will remain so as long as the mode of transmission continues in the present hypothetical condition. There are some, like Teppich, who affirm that tubercle is conveyed to the victim by inhalation, which Weleminsky and Cornets assert is nothing more than a dogma founded on very flimsy conclusions. Ribbert, Hausemann, etc., firmly believe in a hœmogenic infection, while Ravenuls who operated on cattle, Ohnas who experimented on apes,and Jensens on swine, all assure us that it is through the bowel that the infection of tubercle reaches the lung and other organs of the body. We have now come to regard all these channels as possible adits for the poison reaching the system, but when we hear all other ports closed but the bowel we begin to wonder how much we know of the poison at all.

Weleminsky has been experimenting with guinea-pigs since 1900 and has come to the same conclusion as Behring, that human tuberculosis is derived from the bowel, particularly in the food during infancy. He has recently altered his method of experimenting to convince himself of a recent hypothesis that the poison passes by the submental, cervical or bronchial glands to the system and not by the bowel through the mesenteric glands.

He injected tubercle below the chin of the guinea-pig, which in nine days caused the submental glands to swell; in twenty days they became caseous while the cervical and bronchial were also affected, swollen and painful. In the course of thirty-four days the cervical became caseous the bronchial much swollen, and the lung exhibited fine tubercle disseminated throughout its structure.

By subcutaneous injections into the groin the glands enlarged, became painful, and caseous and finally broke down and formed an ulcer. The infection did not stop here, but passed along the lymph channels to the iliac lumbar, and bronchial glands. These enlargements soon caused a congestion in the lymph current affecting the cervical, submental, mediastinal and axilliary glands. From the lumbar glands the mesentery became affected and from the iliac the inguinal, never the centrifugal from the centripetal, till the bronchial glands are reached, which may be considered the centre of the lymph system and to which tubercle flows from every quarter of the body. Thus the tubercle of the lung or infection is derived from the bronchial glands and carried by the blood-vessels to the pleura, forming what we have been pleased to designate "subpleural tubercle," and not transmitted along the bronchi in the lymphatic vessels as met with in infants. Weleminsky has confirmed this method of infection by many experiments, exceeding a thousand.

The question next arises: Can the bronchial glands be infected through any other channel than the lymph passages? To this he answers, No. All his experiments negative any other path of access. When both bronchial glands and lungs are found diseased, tubercle has first attacked the bronchial glands; or, generally stated, the organ never infects the lymph channels and glands but the glands always infect the organ through the lymphatics. His examinations of *post-mortems* in the human subject confirm his opinion formed by his experiments that infection by inhalation is not at all a common mode of transmitting tubercle. When the submental or cervical glands are not enlarged or diseased in the human subject, it is because they have healed, as tuberculosis is of much shorter duration in the guinea pig than in the human subject. To test this glandular infection Weleminsky used the bacillary fluid in the form of a spray, which first exhibited the specific sympto m in the submental and cervical glands, and finally the bronchial, in the same order and with the same intensity as when the animals were fed with the infect ing fluid. No germs or tubercular symptoms could be detected in the lung substance itself, though present in the glands, clearly proving its primary action on the lymphatic system and also that it is taken in from the alimentary canal and not from the lung to the glands. A piece of lung was taken from one o fthese animals which had been sprayed for half an hour, producing the usual enlargement and caseation of the lymphatics of the neck and bronchi, and placed under the skin of a healthy animal, with negative results, clearly proving the absence of tubercle in the lung substance. The narrowness of the air passages in the guinea-pig may be objected to as forming a difference of results, but it may be safely assumed from the above that the poison is more readily taken in by the alimentary canal than the lung. When inhaled and not "aspired" the germ is taken into the air passage, but expelled in the sputum to be partly swallowed and presented to the alimentary canal to be absorbed into the system. Aspiration and inspiration differ in so much as the former may be taken into the trachea direct by some abrasion, and directly affect the bronchial gland, while simple inhalation admits of complete expulsion in the sputum and a transfer to the alimentary canal.

Anthracosis of the lung in the case of miners is often advanced as proof of the deposit of germs in the lung, but the angular nature of the dust causes this to locate itself, which cannot be urged in the case of bacteria.

The tonsils have with a good deal of reason been assigned the portal through which the bacilli pass into the lymph channels, thence to the pleura and finally to the apex of the lung, which is less active and where the blood moves sluggishly to favour the growth and spread of the bacilli.

The practical result of Weleminsky's lecture was the prophylactic advice that all should breathe through the nose, where the bacteria would be entrapped and prevented from reaching the alimentary canal; and secondly, that gymnastics should be largely practised to hasten the circulation in the apex of the lung, and thus resist the danger of lung infection after the lymphatic glands have become affected.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

BELFAST.

THE CORPORATION AND SANITARY AFFAIRS.—The past week has been a sad one for friends of municipal, and especially of sanitary reform in Belfast, and the members of the Corporation stand disgraced before all educated and honest men. The new City Hall, built and furnished at a cost which will not fall much short of half a million, was occupied for the first time on Monday, and on the same day the Corporation refused to accept the suggestion of the public Health Committee that a salary of £800 a year be offered for a competent man as medical officer of health, and at a subsequent meeting they fixed the salary at £600. This might seem to be a wise economy, if it were not well known that it is simply a step towards a flagrant piece of jobbery, which has been protested against in vain by the Ulster Medical Society, the Citizens' Association, and the best section of the Press. Though the Public Health Committee finally resolved on a salary of £800, they "swithered" about it for a long time, and are not entitled to much credit in the matter. If they had chosen to say that the health of the city was in a bad way, that a sanitary expert, trained in modern methods was absolutely necessary, and that if such was not appointed they would resign at once the Corporation could not have withstood them for a week. As it is, their action is open to at least a sus-

picion of being designed as a graceful concession to the wishes of the educated classes of the city, while they knew that their colleagues on the Corporation would not allow their zeal for reform to have any practical outcome.

Meantime an epidemic of typhoid has appeared in the Malone district, one of the best residential parts of the city. Fourteen cases have been notified, and there are said to be as many not notified. In at least eleven of the cases the milk supplied to the families comes from the same dairy, so that a strong suspicion must attach to it as the cause of the disease.

LETTERS TO THE EDITOR.

THE FALLING BIRTH-RATE.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—This subject formed the chief theme of Sir J. Crichton Browne's address before the Sanitary Inspectors' Association on Thursday last. It cannot be said that the address, admirable and powerful as it was, brought forward any new facts; but it gave all the facts in argumentative order, and it ought to do something at least to stimulate the interest of thoughtful men—of thoughtful statesmen—in this tremendously important question. Sir Crichton Browne very wisely laid great stress upon the statistics lately prepared by Mr. David Heron. These statistics prove that the declining birth-rate is most evident among the classes having real claim to the designation "well-bred," whilst the physically, morally, and socially lower classes are reproducing themselves with the greatest rapidity. There can be no doubt the falling birth-rate is due to the wide adoption of the custom which has become practically universal in France—to the wilful and systematic prevention of child-bearing. This latter part—and, indeed, the whole question of the declining birth-rate, whether as regards its influence upon the parents and progeny, or its wider effects upon the State—has been within the last few years very fully debated in the editorial and correspondence columns of the medical Press.

It seems evident that a declining birth-rate due to the cause we have named—and especially a declining rate among the best-bred—must mean a diminishing racial resistance. The racial struggle is not yet over. The forces of evolution are as potent now as in the days of primeval man, and decaying races of the present epoch are as certain to be in time supplanted by more virile stocks as yet unaffected by the vices of civilisation which destroyed many nations of antiquity, and which are showing already their destructive effects upon some of the more advanced among the peoples of Western Europe.

I am, Sir, yours truly,

AN OBSCURE PRACTITIONER.

London, September 14, 1906.

THE DECLINING BIRTH-RATE.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—I am sorry your correspondent "Imperialist" misapprehends my letter, especially as I thoroughly understand his.

A very interesting letter in your issue of March 21st, signed "A Student of Sociology," on the "Census of the Empire," in tone, style of expression, and argument favours "Imperialist." France in that letter represents the scarecrow to frighten the British public. In an article in the *Daily Telegraph* which impressed me (August 27th, 1904), the writer states that "France at this moment is more powerful and influential in Europe than at any moment since the year of débâcle and dismemberment, when her conquerors believed that she had fallen, never to rise again."

The mistake of your correspondent, assuming it one, is to argue on his own hypotheses—that is to say, he assumes France's decadence; secondly, that it is wrought through a declining or stationary birth-rate. Neither of these premisses do I admit without wide discussion—certainly not the latter. I dispute the latter on the ground as stated in my letter—viz., a declining birth-rate would under no circumstances, excepting too remote to be worthy of consideration, cause the downfall of a civilised Power. On the other hand, it would be rather the complex causes which excited or induced this decline that should be held accountable. Let your correspondent find out what these are in the case of our own country, or any other nation with a declining birth-rate, then rectify these, when I venture to state the decline will at once cease and the tide commence to rise. For example, your correspondent may hear the sounds of the "Bitter Cry of the Middle Classes" from the columns of a lay contemporary. He may further discover that excessive competition and taxation render the condition of a large number of the so-called middle classes such as to make it impossible to support numerous progeny; hence they resort to measures to limit their number. Others defer marriage to a later date, whilst the least heroic refuse to marry at all. The state of the last is worse than that of the first, for the simple reason that the celibates in many instances incur and propagate venereal diseases. This is far more likely to induce degeneracy of race than a declining birth-rate. Your correspondent will observe that there are a certain clique of well-meaning, restless people nowadays, comfortably provided for themselves, whose idea is to feed the excessively educated working classes, provide recreation grounds, free libraries, etc., etc.—in a word, to provide everything without payment. This, although commendable, practically means "robbing Peter to pay Paul." Peter, however, represented by the middle classes, is driven to such a dilemma that he reluctantly in most cases seeks aid and refuge in suppressing the birth-rate. The majority of the middle class must either have recourse to this method, or they must necessarily be reduced to pauperism, or join the ranks of the very class whom they have been excessively taxed to attempt to raise to their own standard. I ask if anybody possessed of his senses could urge the British middle class to the doctrine of procreation under these conditions—a doctrine which, if carried out, must inevitably create decadence of a race long before the remote consequences of a declining birth-rate could set in—consequences which are purely hypothetical and imaginary, because, as I have stated, so soon as the causes which prompt individuals to prevent conception are removed or improved, so soon would affairs commence to right themselves, so that we may safely predict that the supposed consequences of a declining birth-rate, such as your correspondent anticipates, would never come to pass.

In my last letter I pointed out that the power of a small nation like our own is influenced only to a slight degree by virtue of its numbers. If otherwise, how would the recent war in the Far East have fared? A correspondent, discussing this question elsewhere, very truly remarked that what we require is "Quality, and not quantity." The British ship, if I may thus designate it, is already over-freighted with human cargo. We have to throw them overboard. This is the simple meaning of emigration, whilst immigration and the too rapid propagation of the human species unequivocally means at the same period taking more on. What could be more fatal to any nation?

I am, Sir, yours truly,

CLEMENT H. SERS.

Brighton, September 7th, 1906.

"QUO VADIS?"

To the Editor of the MEDICAL PRESS AND CIRCULAR.

DEAR SIR,—As an old reader of your much-esteemed journal, I was certainly somewhat surprised at reading the recent article by Dr. Bell Taylor, entitled "Quo Vadis?" So far as I can gather, he condemns vaccination, the isolation of infectious diseases, serum treatment, and holds various other unorthodox views. It is clear that your catholic policy admits statements of views that may be contrary to generally accepted professional views. Personally, I think it a matter of congratulation that at least one of our medical journals

is liberal enough to adopt an attitude of that kind. A free expression of views on both sides of a question is desirable, or, indeed, for that matter, often absolutely necessary, in order to arrive at the truth. All readers of the MEDICAL PRESS AND CIRCULAR must recognise that the editorial views are diametrically opposed to the unorthodoxy of Dr. Bell Taylor. I have written this note because I heard of one medical man who rashly assumed that the views of the writer of "Quo Vadis?" were approved by its mere publication. A moment's reflection shows the absurdity of any such criticism.

I am, Sir, yours truly,
AN ONLOOKER.

Stafford.

[The publication of an article, of course, does not commit the journal to approval of the statements therein. The same rule applies to a letter addressed to the correspondence columns. Were it otherwise, the conditions of editorial life would speedily become intolerable. The policy of excluding all views that are not strictly orthodox from the columns of a journal devoted to the interests of a progressive science like that of medicine is, in our opinion, questionable. At one stage Harvey's views on the circulation were unorthodox, and under such a rule would have been excluded from contemporary medical journals had any such existed. Our policy is to be found in our editorial columns, and not in original communications written by outside contributors.—ED. MEDICAL PRESS AND CIRCULAR.]

CAN THE INFECTION OF SCARLET FEVER PRODUCE PUERPERAL FEVER.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

DEAR SIR,—Now that the appeal in the scarlet fever case following confinement is concluded, I think it a fitting opportunity to discuss the question: "Can the infection of scarlet fever or the acute exanthemata produce puerperal fever?" I would first of all like to express my congratulation to and sympathy with our two medical brethren who have had to endure so much mental strain, and have been put to so much expense, and the hope that the expression of sympathy may take a practical form (they are both strangers to me).

I hold that it is quite illogical to teach that attendance on a case of the exanthemata not complicated by suppuration can convey septic poisoning to a parturient woman—as well might one expect a field of wheat where only grass seed had been sown—or small-pox to be caused by the infection of typhus. Erysipelas and diphtheria come under a different rule, and therefore the reason for continuing them in the list of notifiable diseases.

In years gone by I frequently attended women in their confinements in the same room, and even in the same bed, with measles and scarlet fever, and never once saw septic results. I need hardly say that I do not advocate the continuance of this practice, on account of the fear of infection to the baby. Of course, no prudent man would attend a confinement after examining suppurating glands or running ears or nose without taking the same minute precautions which he would deem necessary after making a post-mortem on a putrid body, or opening a foul abscess. After a very long and extensive experience, I hold that the exanthemata may be conveyed to the parturient woman the same as to any other person, but puerperal fever never, the only exceptions being erysipelas and diphtheria.

I am, Sir, yours truly,
JAMES HAMILTON, M.D., Q.U.I.

60, Sydney Street, Chelsea,
September 15, 1906.

OBITUARY.

THOMAS HARRIS, M.D.LOND.

WE regret to announce the death of Dr. Thomas Harris, of Manchester, which occurred somewhat suddenly at Brewood, in Staffordshire, on the 8th inst. He had a distinguished academical career. He was first in first-class honours in physiology at the first M.B. London, 1878-9. He took his M.B. degree with first-class honours in 1882, qualifying for gold medal, and his M.D. a year later. Dr. Harris was at the time of his death lecturer on diseases of the respiratory organs at the Manchester University, a position he filled for several years. Before holding that appointment he was pathologist to the Manchester Royal Infirmary and assistant to the Professor of Pathology at the University. Subsequently he became physician to the Manchester Infirmary, and physician in charge of the throat department. He was at one period on the active staff of the Consumption Hospital, and at the time of his death held the office of consulting physician. His medical writings were numerous. Perhaps his most important book was "Indurative Mediastino-Pericarditis," published in 1895. He wrote also a Post-mortem Handbook and published "Clinical Lectures on Pathology and Diagnosis of Early and Late Stages of Pulmonary Phthisis," as well as many papers in the medical journals.

JOHN HENRY BELL, M.D. ST. AND., M.R.C.S.ENG.

WE regret to announce the death of Dr. John Henry Bell, of Bradford, for many years a prominent member of the medical profession at both Leeds and at Bradford, at the age of 74. Coming of a well-known Scottish family, he was born in Bradford, the son of Mr. W. Bell formerly of Kirkcudbrightshire. In 1857 he started practice at Bradford and rapidly gained a large clientèle, and was elected on the staff of the Bradford Infirmary. He gave special attention to anthrax, and wrote on the subject in Allbutt's "System of Medicine," and other articles of the same nature, including "Anthrax in its Relation to the Wool Industry. He was president of the Bradford Medico-Chirurgical Society, a member of the Royal College of Surgeons, and a Licentiate of the Society of Apothecaries. In 1861 he took the degree of M.D. at St. Andrews.

EDWARD GAYLOR, L.R.C.P.EDIN., L.F.P.S.GLAS., D.P.T., OF BELPER.

WE regret to announce the death of Dr. Richard Gaylor, of Belper, in his seventy-sixth year. In spite of a long life spent in medical practice, he kept in harness to the last, and was attending to his duties as medical officer of health within a few days of his death. Deceased was born at Morden, in Herefordshire, received his medical education at Sheffield, whence he qualified as L.R.C.P.Edin. and L.F.P.S. Glas., in 1865. He contributed articles on various subjects to the medical journals. Dr. Gaylor was prominently engaged in the public life of Belper during the last half century, especially as regards politics. He was not less widely known than he was highly esteemed in the country.

SPECIAL ARTICLE.

THE SOURCES OF GOVERNMENT VACCINE LYMPH.

WE have been asked to publish the following correspondence which has taken place between Sir William Collins, M.D., M.P., and the President of the Local Government Board in reference to the original sources of the lymph supplied by the National Vaccine Establishment for the purposes of public vaccination:—

House of Commons,
July 8, 1906.

DEAR MR. BURNS,—

In consequence of your negative reply to my question put to you on June 28th asking for a Return showing, as far as is known, the original sources of the vaccine lymph now in use, and at your own request, I put down another question on the same subject on July 4th. The answer to this does not contain the information asked for.

I think the public have a right to know what are the

original sources of the lymph used or supplied by the National Vaccine Establishment. If the sources are not known, why not say so? If they are known, why not state them?

I know the lymph is cultivated on a series of calves, but what is the original source from which the lymph was obtained? Vaccine vesicles do not appear spontaneously either on the shaven abdomens of calves or on babies' arms.

Before the Royal Commission great importance was attached to the original sources of lymph, as, indeed, was the case with Dr. Jenner himself. We were informed that results resembling vaccine could be obtained from such varied sources as horse grease, cattle plague, small-pox, sheep-pox, syphilis, and from the inoculation of tartar emetic.

I want to know how many strains are now in use, whence they were obtained, and what investigations were made into the genuineness of the disease in the animal originally yielding the lymph.

Yours sincerely,
W. J. Collins.

The Right Hon. John Burns, M.P.
Local Government Board,
Whitehall, S.W.,
July 13th, 1906.

Dear Sir William,—

Adverting to your letter of the 8th instant, with regard to the original sources of the vaccine lymph supplied by the National Vaccine Establishment, I may say that I have answered several questions in the House on this subject, but since the receipt of your letter I have again gone into the matter very carefully.

In view of the Act of 1898, and of the adoption by the Government of glycerinated calf lymph for all public vaccinations, the Local Government Board made an entirely new departure as regards the source of vaccine lymph. Dr. Blaxall, the newly-appointed Director of the Board's Glycerinated Lymph Establishment, obtained as stock for starting his series of calf-to-calf vaccinations lymph from Cologne. This lymph which had been long in use there, and had originally been obtained, it was believed, by vaccinating calves from the arms of infants, has continued to be employed in the vaccination of calves at Lamb's Conduit Street to the present day.

Side by side, however, with this calf-to-calf lymph of Cologne pedigree, other lymph has from time to time been taken into use at the Board's establishment. This other lymph has been partly retro-vaccinated Cologne lymph—*i.e.*, lymph passed from the English infant back to the calf (after glycerination) to the infant again, and partly it has been lymph newly obtained from continental stations and passed through a series of calves before adoption for use in the Board's Establishment.

With regard to the "original" sources of lymph of the latter kind, I may remind you that in my reply to your question in the House of the 28th ultimo, I said, referring to the fact that in some instances lymph has been obtained from abroad, that "in such cases it would usually not be practicable to give its original sources," and in this connection I may also refer you to the reply which I gave to a question by Mr. J. W. Benn on March 23rd last, in which I stated that "occasionally lymph has been procured from abroad," and it is possible that in some instances of this kind the lymph may have been originally derived from artificial inoculation of calves with small-pox, but in no case is lymph used at the establishment unless it has been passed through a series of calves.

Yours truly,
John Burns.

House of Commons,
July 14th, 1906.

Dear Mr. Burns,—

I am much obliged for your communication of 13th inst., but neither in it nor in any of the replies to the many questions put to you in the House can I find any definite information as to the point on which I sought information, viz.: the *original sources* of the lymph supplied by the National Vaccine Establishment.

To say that lymph was brought from Cologne, and that it was there obtained by vaccinating calves from infants' arms, tells nothing of its original source or the nature of the disease from which the strain was originally derived.

Is it really not possible to say whether the lymph supplied by the National Vaccine Establishment was derived originally from the small-pox of man, the pox of the horse, or from an eruption on the teats of a cow, and if the latter, whether it was the true or spurious cow-pox?

Yours very truly,
W. J. Collins.

The Right Hon. John Burns, M.P.
Local Government Board,
Whitehall, S.W.,
July 24th, 1906.

Dear Sir William,—

Adverting to your further letter, I am afraid I cannot add much to what I have already said.

As to the remote ancestry of the Cologne lymph, whether it was derived from casual cowpox or induced cowpox, we do not know.

The Department were satisfied when it was adopted, that it was producing and had long been producing in calves what the German experts regarded as characteristic vaccinia, and that lymph transmitted from such calves to babies protected them against small-pox.

Yours truly,
John Burns.

Sir W. J. Collins, M.P.
House of Commons,
July 28th, 1906.

Dear Mr. Burns,—

Thanks for your further letter of 24th. I am sorry that the Local Government Board cannot vouchsafe any information as to the original sources of the lymph supplied by the National Vaccine Establishment.

As to the Cologne stock, may I ask you to be so good as to refer me to the evidence on which your department were satisfied as to its character Was it tested by the variolation or attempted variolation of those who had been vaccinated with it?

Yours truly,
W. J. Collins.

No reply has been received to this letter.

The questions referred to in the correspondence are the following:—

Thursday, June 28th, 1906.

Sir William Collins asked the President of the Local Government Board if he will grant a return showing, as far as is known, the original sources of the various stocks of lymph which have been, or are being employed by the National Vaccine Establishment, indicating those strains which are no longer in current use.

Mr. John Burns said: As I have stated in reply to previous questions, the usual method of renewing lymph supplied from the National Vaccine Establishment is by vaccinating calves with vaccine lymph obtained from children, but in some instances the lymph has been obtained from abroad, and in such cases it would usually not be practicable to give its original sources. In these circumstances I do not think that a Parliamentary Return of any value could be given. I may, however, state that in no case is lymph used at the Establishment unless it has passed through a series of calves.

Wednesday, July 4th, 1906.

Sir William Collins asked the President of the Local Government Board if he will state the original sources from which the stocks of lymph now used or supplied by the National Vaccine Establishment were derived—whether obtained in this country or from abroad—and the evidence upon which the genuineness of the vaccine derived from the animal originally yielding the same was established.

Mr. John Burns said: I think I must refer my hon. friend to my reply to the question on this subject which he put to me on the 28th June last; but I may add that no lymph which on being passed through a series of calves is productive of appearances differing in any way from those characteristic of vaccinia in the calf is issued from the National Vaccine Establishment.

MEDICAL NEWS IN BRIEF.

An Anti-Vivisectionist Monument.

A "MEMORIAL to a little brown dog" was unveiled by the Mayor of Battersea (Mr. W. Rines) in the Latchmere Recreation Ground, Battersea, on Saturday afternoon. The fountain was presented by the International Anti-Vivisection Council, and has been constructed in memory of a little brown dog whose bronze model surmounts it. On one side of the fountain is the following inscription:—"In memory of the brown terrier dog done to death in the laboratories of University College in February, 1903, after having endured vivisection extending over more than two months and having been handed over from one vivisector to another, until death came to his release." The fountain cost £130, which was raised by subscription among the members of the International Anti-Vivisection Council, who first of all applied to the London County Council for permission to erect the fountain in Battersea Park. Failing to get this permission they presented the fountain to the Borough Council. An action for libel has been threatened, and was at first derided by Battersea councillors, but on Wednesday the Council put its seal to an agreement whereby the International Anti-Vivisection Council undertook to indemnify the Corporation against all risks. Earnest money to the amount of £300 has been deposited. At the unveiling the Mayor was supported by Lady Seafield, Lady Nina Ogilvie-Grant, and the Rev. C. Noel. Mr. Jeffery, L.C.C., formally presented the fountain. The Mayor of Battersea accepted the gift on behalf of the municipality. He said the gift was accepted despite threats of all sorts of pains and penalties. In the interests of humanity the Council were prepared to take whatever consequences might come to them. Mr. West and Mr. Watts, formerly mayors of the borough, proposed and seconded a vote of thanks to the donors. The uncompleted recreation ground, which has been laid out by the unemployed, was afterwards declared open by the Mayor, who said that in the event of any threats being put in operation he hoped all present would constitute themselves custodians of the little brown dog.

Danger of Tea Drinking.

DR. WYNN WESTCOTT, at an inquest at Hackney last week, declared that to drink tea with meat was one of the most injudicious things that could be done. The inquest was held on the body of a woman music teacher, who died suddenly while giving a lesson. The evidence showed that just before the lesson began a heavy meal of beefsteak, tomatoes, and tea had been taken in a hurry. An autopsy showed that the meat was not digested, and a doctor declared that it had caused syncope. The coroner said that tea prevented the flow of the gastric juice which was necessary to digestion. "Water with meals, or beer, if one had the wickedness to drink it, was far better than tea," he said. "I am sorry," Dr. Westcott continued, "if anything I have said goes against teetotal doctrines, but if people must be teetotalers they had best drink water and not tea. Tea is all very well between meals, when it can do no harm." A verdict of "Death from natural causes" was returned.

The Cost of Pauper Lunatics.

AT the request of the Finance Committee of the London County Council, the Asylums Committee have drawn up a report upon the causes which have led to the increase in the weekly charge for the maintenance of each patient in the London County asylums from 9s. 1½d. in 1890-01 to 11s. 4½d. in the year 1904-5. From this report it appears that, whereas in 1890 the actual expenditure for the maintenance of lunatics was £174,360, this had risen in 1904 to £498,393. During the period under review the number of patients has largely increased, and several new asylums have been provided. The committee account for the increased maintenance rate by pointing out, in the first place, that all the officers and attendants have been placed under improved conditions of service and pay, while the ratio of attendants to patients in all the asylums has been largely increased. In the new asylums the wards are, in conformity with modern ideas, made considerably smaller than in the older institutions, and this in itself necessitates the employment of a larger staff. No male adult servant in the employment of the committee receives remuneration equivalent to less than 25s. a week. The increased weekly expenditure per patient of 5.23d. for provisions is accounted for by an improved and increased dietary and an improvement in the standard of the articles supplied, as well as by the higher contract prices of certain articles which now obtain. English-killed beef has been substituted for frozen beef and an addition of 2oz. per patient weekly has been made to the allowance of meat. The staff dietary has also been largely improved. Increased expenditure is also shown under the heads of necessaries (including fuel, lighting, washing, furniture, and property), surgery and dispensary and rates. Even with this increased expenditure, a comparison of the cost at London County asylums with that at the extra-metropolitan asylums is generally favourable to the London asylums. Certain economies have recently been effected in asylum administration, and the committee hope that from the present time the weekly maintenance rate per patient will work out at 11s. 1d.

The Outbreak of Typhoid at Basingstoke.

AFTER the recent outbreak of typhoid fever at Basingstoke, the cause of which was traced to the town water supply, the borough council had 50 actions for damages entered against them in the High Court, the sum claimed as damages being nearly £4,000. So serious was the outbreak that many of the victims had to be helped by a relief fund. A committee of the claimants was afterwards formed, and this committee agreed to meet a committee of the Ratepayers' Association to adjust the claims, and the result has been that the council have agreed to pay £1,670 15s. in settlement of the 50 claims brought, without prejudice and with denial of liability. Since the epidemic the town has gone to a fresh source for their water supply. —*Times.*

Milk Sold from Infected House.

A PECULIAR case, having a connection with the epidemic of typhoid fever last week on the banks of the Noran, was heard in Forfar before Sheriff Lees. Mrs. Mabel Sampson, wife of a farmer, Noranbank, was charged with having contravened the Public Health (Scotland) Act in so far that while living in an infected house, she engaged in active connection with food by supplying milk to James Robertson, Noranside. Accused pleaded guilty, and Mr. Philip appeared for the Brechin District Committee. He stated that there had been an epidemic of typhoid fever on the banks of the Noran for some time, and it was still going on. Mrs. Drummond was one of the first sufferers, four of her children being attacked. She seems to have foolishly sold a pennyworth of milk, and did it more for obligement than profit. The Brechin District Committee did not ask for a severe penalty seeing accused had suffered a great deal as the result of the epidemic. Sheriff Lee modified the sentence to a fine of 1s. and 1s. of expenses, or three days' imprisonment.

Sanitary Officials' Congress.

DELEGATES assembled last week at Blackpool for the annual Congress of Sanitary Inspectors. They were formally welcomed at the Town Hall in the afternoon by the Mayor (Mr. W. H. Broadhead). The business of the Conference opened with a presidential address by Sir James Crichton Browne. Among other interesting papers may be mentioned those of Dr. Hyslop, of Bethlehem Hospital, Southwark; Dr. Hope, Medical Officer of Liverpool; Mr. Robert Lindsay, Sanitary Inspector, Edinburgh; and Mr. James McPhail, Chief Food Inspector, Hull.

Measles in Cheshire.

AN extensive epidemic of measles is reported from Haslington, near Crewe, and that the schools have had to be closed. There are said to be also cases at nearly every house in Crewe. The attendance at school is considerably affected by the prevalence of the malady. One of the infants' schools was ordered to be closed, but this does not appear to have done much to check the spread of the disease.

Apothecaries' Hall of Ireland.

THE autumn sessional examinations will commence with the First Professional on Monday, October 15th, 1906. Entries, schedules, &c., must be lodged at least fourteen clear days beforehand, with the Registrar, 30, Mary Street, Dublin.

AN unusually virulent outbreak of diarrhœa is reported in certain villages of south-east Lancashire. Hundreds of cases have been under treatment during the past few days, and nearly a score of deaths—chiefly among children—have been notified in the above-named localities. Many factory operatives are incapacitated from work.

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A Guide to Diseases of the Nose and Throat and Their Treatment. By Charles A. Parker, F.R.C.S.Edin. Illustrated. Pp. 694. Price 18s. net.
Midwifery for Nurses. By H. R. Andrews, M.D., M.R.C.P.Lond. Pp. 308.

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Introduction to a New Method of Respiratory Vocal Re-Education. By F. Matthias Alexander. Pp. 24. Price 1s. net.
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Tuberculosis: Its Origin and Extinction. By W. Prickett Turner, M.D. Pp. 96. Price 2s. 6d. net.

BRADLEY PRINTING Co. (Philadelphia).
Philadelphia Hospital Reports. Vol. VI., 1905. Edited by Herman B. Allyn, M.D.

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The Royal London Ophthalmic Hospital Reports. Vol. XVI. Part IV., June, 1906. Edited by William Lang, F.R.C.S.Eng. Pp. 583. Price 5s. net.
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Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT MEDICAL LITERATURE.

Enlargement of the Spleen in Rickets. — Cowan and McClure (*Brit. Journ. of Children's Diseases*, August, 1906) have undertaken an investigation to ascertain the exact relationship of enlargement of the spleen in rachitic children to the disease itself. In the middle of the seventeenth century, Glisson had drawn attention to the fact that the viscera are sometimes enlarged in this disease, but even among modern writers there appears to be little agreement as to the exact histology of this enlargement. Dickinson, writing in 1869, describes four cases giving the microscopical appearances of the affected organs and making it clear that the changes found were due, not to the presence of any formation foreign to the structures of the viscera, but to an irregularity of growth which altered the normal proportions of their tissues; the condition he thought was *sui generis*. Later writers are by no means agreed as to the proportion of cases in which enlargement of the spleen occurs or whether such enlargement, if it does occur, is to be looked on as part of the disease or a mere coincidence. Drs. Cowan and McClure have made an examination of 417 consecutive cases of rickets at the Dispensary of the Royal Hospital for Sick Children, and found the spleen "palpable" in 17, or 4.07 per cent. In only eight of these seventeen cases were they definite that the spleen was really enlarged, and in five of these eight there was considerable thoracic deformity. Trousseau had maintained that though the spleen in rickety children might often be felt below the ribs, yet it was not enlarged, but that the prominence was due to displacement as the result of thoracic deformity. Among Dr. Cowan's and Dr. McClure's cases there were only two with notable enlargement of the spleen. In one of these cases the blood revealed changes characteristic of splenic anæmia, and the patient in the second case was suffering from measles and died in the attack. The writers conclude that "it seems improbable splenic enlargement is merely an incident of rickets, when the viscus is only palpable in less than 5 per cent. of cases. In our opinion notable enlargement of the spleen in rachitic children is the result of other causes than rachitic, the most common of which are splenic anæmia and congenital syphilis."

K.

Air Dilitation in the Treatment of Chronic Constipation.—Hirschman (*Med. Record*, August 11th, 1906) discusses this method of treating chronic constipation. He has devised a simple pneumatic dilator for distending the rectum or sigmoid. This consists of a rubber bag with a stem which is slipped over the distal end of a Wales bougie (No. 3-5). Compressed air at a low pressure is allowed slowly to enter the bag, and distension to any desired extent is produced. Where the compressed air apparatus is not convenient a small bicycle pump may be utilised. The patient is placed in the Sims position. The bag is deflated, lubricated, and passed up into the rectum or through the rectum into the sigmoid to any desired height. When in position the bag is slowly inflated until the patient complains of a sense of either fulness or pain, or a desire to move the bowels. The air is then allowed to escape and after an interval of a few seconds it is again inflated to the point of tolerance. This alternate inflation and deflation is repeated four times to the minute for about five minutes. The bag is then again inflated to the point of tolerance, the opening in the bougie closed by the thumb, and by â to and fro motion the apparatus is gently and slowly withdrawn. This massages the bowel as it is withdrawn and also gently dilates the sphincter. The treatment is continued daily for about a week and then at longer intervals. Dr. Hirschman says that in an experience extending over nine months he can recall but two cases in which success was not obtained. In about 80 cases, so far as he has been able to learn, permanent good results were obtained.

K.

Extensive Ringworm.—Sequeira (*Brit. Journ. of Dermatology*, August, 1906) records two cases of extensive ringworm of the trunk occurring in patients who lived in London and who had not been in contact with people who had been in the tropics. The first case was that of a boy, æt. 14, who had been affected since he was 7 years old, and who applied for treatment for an ulcer, the size of a crown piece, about the umbilicus. Almost the entire trunk, parts of the arms, the hands, and front of the feet were found to be infected with ringworm. The finger nails were extensively infected but the toe nails had escaped, the face and scalp were also unaffected. The eruption itched a good deal and the boy was constantly scratching. There was no evidence of visceral disease, and the boy was well developed, but thin and anæmic. The second case was that of the boy's sister, æt. 21, and she had been infected with the disease since 7 years of age. In her case the distribution was not nearly so extensive, but the finger nails were infected; the face and scalp with her, like the boy, had escaped. In each case scrapings from the skin and nails showed a large quanity of mycelium and some spores. The fungus in both proved microscopically to be the common endothrix. The exudate from the ulcer in the boy's case also contained the fungus. The girl refused treatment, and the boy's parents refused to allow the nails to be removed, so that complete cure was impossible.

K.

Diagnostic Significance of Ocular Reflexes.—Kempner (*Berlin Klin. Woch*, 1906) has been studying this subject on hundreds of persons, including 350 cases of organic affections in the domain of the trigeminus, and 400 without organic trouble. After discussing the anatomy and physiology of the parts, he tabulates his findings in detail and classifies the cases. When the corneal reflex was absent or diminished, this occurred on one side only in the cases of organic affections, while it was bilateral in the functional disturbances. In the organic cases, the anomaly in the reflex was generally accompanied by sensory disturbances affecting the trigeminus or some of its branches, while in the merely functional cases there were no sensory disturbances, or if present they did not correspond to the trigeminus area. In cases of a tumour in the posterior cranial fossa the cornea was first affected, then the rest of the first division of the fifth nerve, and then the second, and finally the third division, while in the true functional cases the reflex anomaly and the sensory disturbances were not progressive and were not liable to alternate irregularly. In four cases the diagnosis wavered between tumour of the cerebellum and hydrocephalus; the corneal reflex was normal or exaggerated. Hydrocephalus was found in the two that came to autopsy.

D.

The Use of Thyroid Extract to Shorten Coagulation Time of the Blood.—Dr. Wm. Taylor (*Boston Med. and Surg. Journ.*, July 26th, 1906) advises that thyroid extract be used in cases of hæmophilia where operation was demanded or where they had received any accidental wound, and also in patients whose blood had been altered by disease. He stated that normal blood was not affected in any way by the use of thyroid extract, even where its use had produced distinct constitutional defects, that it acted only upon blood which lacked fibrin ferment. He mentioned the fact that A. E. Wright had found that the coagulation time of the blood was lengthened by starvation

and shortened immediately after a hearty meal, and the efficiency of the action of calcium chloride was increased by combining it with an albuminous substance, such as an aqueous extract of thymus, thyroid, testicle, gastric, and other mucous membranes. He cited three cases of bleeders in which thyroid extract was used with marked benefit, and mentioned one instance in which it was used in a case of profound jaundice due to obstruction of the hepatic duct. He recommended that in all cases of suspected or probably delayed coagulation time the blood should be carefully tested and the dried thyroid extract given in 3-grain doses in capsules three times a day, and stated also that it had been used with very great effect in several cases of purpura with spongy and bleeding gums, occurring during the course of typhoid fever. D.

Signs n Congenital Tendency to Tuberculosis. —Sorgo a d Suess (*Wien. Klin. Woch.*, Vienna, 1906) have found in their experience that the mamma on the side of a unilateral tuberculous process is always smaller in all respects than its mate. Among 111 tuberculous female patients examined, the areolæ were of unsymmetrical size in 52, and among these the tuberculous process was unilateral in 18. In every instance the smaller nipple and areola were on the side of the morbid process (right 12, left 6). In 19 others the process was predominant on one side, and this side was always that of the smaller areola (right 5, left 13). Similar proportions were found in 168 male tuberculous patients examined. The findings suggest an unmistakable connection between the comparative atrophy of the one breast and the predisposition to tuberculosis of the lung beneath. D.

Phlegmonous Enteritis. — MacCallum contributes an article on this rare affection to the August number of the *Johns Hopkins Hospital Bulletin*. In all, seven cases up to this have been recorded, in five of which the inflammation was limited to the upper part of the small intestine; in one the colon, and in one the whole of the digestive tract was involved. The case now reported is that of a negro, æt. 75, who was admitted to hospital suffering from abdominal pain and vomiting Three weeks previously he had met with an accident and had got a scalp wound, but had apparently completely recovered from the effects of this. The day before admission, he first suffered from the abdominal pain, which rapidly grew worse. On admission he was much collapsed, and presented symptoms and signs of intestinal obstruction. A laparotomy was performed, and the wall of the upper part of the jejunum was found thickened and brawny-looking, but without any signs of kinking or strangulation. Nothing further was done, as the patient was too weak to allow of further manipulation, and death occurred some hours later. At the necropsy the lumen of the thickened part of jejunum was found full of soft, yellowish-white material, and the valvulæ conniventes stood up as thick, opaque, rigid and swollen folds. On making an incision the submucosa was seen to be greatly thickened, and yielded a turbid fluid on pressure. Microscopically, this coat, and also the muscular coats and muscularis mucosæ were found infiltrated with cells, both lymphocytes and neutrophile leucocytes, and with fibrin, while in addition the lymphatic channels were engorged with cells, and a thin layer of fibrin was present on the peritoneal surface of the gut. The causative organism was not isolated, but from its appearance in stained sections, there was little doubt that it was the streptococcus pyogenes. It is supposed that traumatism may have some effect in causing this lesion, the upper part of the intestine being more readily injured on account of its relatively fixed position. In support of this view it is to be noted that the epithelial lining of the interior of the gut was intact in this case, and in other recorded instances. M.

The Treatment of Infantile Paralysis by Nerve-Anastomosis. — Hackenbuch (*Deutsch Med. Woch.*, 1905, No. 25) has treated three cases of paralysis of the peroneal group of muscles in children due to anterior poliomyelitis, by means of nerve anastomosis. The operation consisted of exposing in the popliteal space both tibial and peroneal nerves by an incision over three inches in length. Then he separated from the stem of the tibial nerve a flap of about one-third of the thickness of the entire nerve stem, and in such a manner that it remained in continuity with the central end of the nerve. This flap was then attached to the peroneal trunk; the wound was stitched up, a small gauze drain being inserted, and a splint was applied. After ten days the splint was removed, and a simple bandage put in its place. Healing had by this time taken place. In two of the cases no improvement took place, possibly, according to the author, owing to a keloid thickening of the scar extending in to the nerve suture. Both of these cases were in quite young children, and in both the paralysis was definitely limited. On the other hand, a splendid result was obtained in the third patient, and had first shown itself nearly two years before the date of this report. The patient was a girl, æt. 12, who had had paralysis of the left leg for ten years. A total paralysis of the peroneal group and of the extensor longus and brevis digitorum muscles was cured, and the patient is now able to use her foot normally both in standing and walking. M.

Myasthenia Gravis.—Albertini (*Bull. delle Scienze Med.*, 1906) has had the opportunity of observing two cases of this malady, one in a male, and the other in a female. In the man the first symptom was intense weariness, which during the last four years set in suddenly after any severe exertion. Later came lingering pains in the upper extremities. No great change had taken place for some time. The woman had suffered for two years from headache and vertigo. Later on appeared tremors, nausea, palpitation, cloudiness of vision, and general weakness; then a feeling of great weariness, and painful respiratory movements. The author regards the diagnosis in both cases as certain, and has been able to exclude such possibilities as traumatic neurosis and hysteria. He does not consider the absence of bulbar symptoms as of importance, as they only appear in the very late stages. Commenting on the condition, he states that it essentially consists of hypotonia, and of a persistent fatigue of the nerve centres, which control the reflex motor functions, especially those which control respiration and the vaso-motor functions. Coupled with the above there exists depression of the intellectual faculties and a rapid wearying of the nerve centres which functionate intermittently, including those that govern voluntary motion. The only cause that seems at all likely to be present is some toxin acting on the nerve-centres. Treatment consists in rest and the removal of all nerve excitants. Massage, galvanisation, and drugs are useless. M.

Vesipyrin: A New Anti-rheumatic and Urinary Disinfectant. — According to the chemical formula, vesipyrin stands in the same relation to salol, as aspirin does to salicylic acid. The conclusions that Hoffman and Luders (*Therapie der Gegenwart*, 1905, No. 2) have come to concerning it are as follows: On account of its being broken up in the intestine and entering the blood as salicylic acid, it is a true anti-rheumatic and a true urinary disinfectant. Further, it is superior to the similar and better known remedies, in that it has no tendency to cause nephritis. It does not irritate the stomach, and is well borne, because the decomposition into salicylic acid does not take place till the intestine is reached. It lends itself, moreover, to the treatment of patients who are not confined to bed, because little or no sweating is caused by its use. As special indications for its therapeutic employment, the authors mention cystitis, pyelitis, and all conditions which require disinfection of the genito-urinary tract, as well as articular rheumatism, neuralgia, and influenza. An ordinary day's dose may be from 2 to 5 grammes. It is best dispensed in the form of tablets, which render it completely tasteless. M.

NOTICES TO CORRESPONDENTS, &c.

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

READER.—You can still get W. E. Henley's little book "In Hospital" The poems form a record of his experience in the Edinburgh Infirmary in the early seventies. His work, either medical or poetical, was never impaired by his exhausting illness, tuberculous arthritis.

DR. S. (Bath).—You will get comparatively little for your books. Some could be disposed of privately, but a dealer will only give you so much a hundred. Books which have cost 35s. often go for 5s.

PREPARATION.—The "Harrington" formulæ is:—

Alcohol (94 per cent.) - - -	640 cc.
Hydrochloric Ac. - - - - -	60 cc.
Water - - - - - - - - -	300 cc.
Perchloride of Mercury - -	·8 grammes.

AU PIED DE LA LETTRE.

LITERATIM.

In Washington there is a slab
Erected unto Hahnemann,
And on it there is chiseled large
A warning unto any man.

For underneath the statue stands
This motto in the centre,
Similia similibus,
And under it, *curentur*.

And can it mean, "Who reads should run,"
In grammar homeopathic,
Remorse and good advice in words
Significantly graphic?

Or does *curentur* promise cures,
A jolly kind of banter?
Or was some conscientious soul
Afraid to write *curantur*?

—*American Medicine.*

N.B.—With acknowledgement.

PELVIS.—Bandelocque's pelvimeter has been modified by many obstetricians. You will find Martin's the most handy for all-round purposes.

FEBRIENTA.—The term, simple continued fever, should not be used if it can possibly be avoided, but it cannot be said to be inadmissible.

MIDWIFE.—Four certificates, not three, are required. One is that of good character, and the other three relate to training. Special forms are prescribed for all.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, SEPTEMBER 19th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—10 a.m.: Diseases of the Throat, Nose, and Ear. Diseases of Children. 2 p.m.: Medical and Surgical Clinics. 2.30 p.m.: X Rays. Operations.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. P. L. Daniel: Clinique. (Surgical.)

THURSDAY, SEPTEMBER 20th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—2 p.m.: Medical and Surgical Clinics. 2.30 p.m.: X-Rays. Operations. Diseases of the Eye.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical).

FRIDAY, SEPTEMBER 21st.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—2 p.m.: Medical and Surgical Clinics. 2.15 p.m.: Diseases of the Throat, Nose, and Ear. 2.30 p.m.: X-Rays. Operations. Diseases of the Skin.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. E. Waggett. Clinique. (Ear.)

SATURDAY, SEPTEMBER 22nd.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—10 a.m.: Diseases of the Throat, Nose, and Ear. 2 p.m.: Medical and Surgical Clinics. 2.30 p.m.: X-Rays. Operations.

Vacancies.

Great Northern Central Hospital, Holloway. — Pathologist and Curator. Salary £100 per annum. Applications to L. H. Glenton Kerr, Secretary.

Liverpool Infirmary for Children.—House Surgeon. Salary £100 per annum, with board and lodging. Applications to Arnold J. Cleaver, Government Buildings, Liverpool.

Cardiff Union.—Assistant Medical Officer. Salary £130 per annum, with rations, apartments, attendance, and washing. Applications immediately to Arthur J. Harris, Clerk, Union Offices, Queen's Chambers, Cardiff.

Sussex County Hospital, Brighton.—House Surgeon. Salary £100 per annum, with board and residence in the hospital, with washing. Applications to the Secretary.

Egyptian Government.—Ministry of Education.—Professor of Midwifery and Gynæcology. Salary £400 a year, with private practice. Applications to the Director, School of Medicine, Cairo, Egypt.

Egyptian Government.—Ministry of Education.—Medical Tutor and Registrar to Kasr-El-Ainy Hospital. Salary £400 a year. No private practice. Applications to the Director, School of Medicine, Cairo, Egypt.

Manchester Education Committee.—Assistant Medical Officer. Salary £200 per annum. Applications to Charles Henry Wyatt, Director of Elementary Education, Deansgate, Manchester.

Bromyard Union.—Medical Officer required for No. 1 District.—Particulars of E. L. Cave, Solicitor, Bromyard. (See advt.)

St. Pancras and Northern Dispensary, 126 Euston Road.—Resident Medical Officer. Salary £105 per annum, with residence and attendance. Applications to the Hon. Secretary, H. Peter Bodkin, 23, Gordon Street, London.

Bedford County Hospital.—House Surgeon. Salary £100 per annum, with apartments, board, and laundry. Applications immediately to W. F. Morley, Secretary.

Oldham Infirmary.—Senior House Surgeon. Salary £100 per annum, with board, residence, and washing. Applications to the Rev. Philip Lancashire, Hon. Sec., Oldham Infirmary.

North Riding Infirmary, Middlesbrough.—House Surgeon. Salary £100 per annum, with residence, board, and washing. Applications to Chas. Postgate, Secretary.

The Chorlton and Manchester Joint Asylum Committee.—Resident Medical Officer. Salary £150 per annum, with board and residence. Applications to Henry Woodhouse, Clerk to the Joint Committee, Chorlton Union Offices, All Saints, Manchester.

City of Birmingham Asylum, Rubery Hill, near Birmingham.—Assistant Medical Officer. Salary £150 per annum, with furnished apartments, board, &c. Applications to the Medical Superintendent.

Fermanagh County Infirmary.—House Surgeon. Salary £52 per annum. Applications to Mr. C. Wilson, Secretary. (See advt.)

East London Hospital for Children and Dispensary for Women, Shadwell, E.—Medical Officer for the Casualty Department. Salary £100 per annum. Applications to W. M. Wilcox, Secretary.

Appointments.

CANN, F. J. H., M.B.Lond., Certifying Surgeon under the Factory and Workshop Act for the Dawlish District of the county of Devon.

CORNER, S. G., M.B., Ch.B.Edin., House Surgeon at the Essex and Colchester Hospital.

DODGSON, GEORGE STANLEY, M.B., B.C.Cantab., Medical Officer to the Sherburn Hospital, near Durham.

FLITCROFT, THOMAS E., L.R.C.P. and S.Edin., L.F.P.S.Glasg. Resident Medical Officer at the Warrington Union Infirmary.

JEFFREY, G. RUTHERFORD, M.B., Ch.B., Senior Assistant Physician to the Crichton Royal Institution, Dumfries.

ROBERTS R. J., L.R.C.P. and S.Edin., Certifying Surgeon under the Factory and Workshop Act for the Corris District of the counties of Merioneth and Montgomery.

THOMAS, A. H., L.S.A., Certifying Surgeon under the Factory and Workshop Act for the West Drayton District of the county of Middlesex.

WILSON, WILLIAM CHEYNE, M.D.Edin., Honorary Physician to the Devon and Cornwall Certificated Industrial School for Girls, Plymouth.

Births.

EWART.—On Sept. 14th, at The North House, Claybury, Essex, the wife of Charles Theodore Ewart, M.B., of a daughter.

RENNY.—On Sept. 11th, at St. Mary's House, Colchester, the wife of E. G. Renny, M.R.C.S., L.R.C.P., of a son.

Marriages.

ADAMS—GRABHAM.—On Sept. 13th, at St. Mark's Church, Surbiton, Cecil Newton, youngest son of the late Francis Adams, of Surbiton, to Beatrice, youngest daughter of the late Charles Grabham, M.D., of Pontefract, Yorkshire, and Mrs. Grabham, Surbiton.

HOWLAND-CARRINGTON.—On Sept. 11th, at St. Saviour's, Walton Street, London, S.W., Goldwin William Howland, M.B.Toronto, M.R.C.P.Lond., eldest son of the late William Holmes Howland, to Margaret Christian, only child of William T. H. Carrington, M.Inst.C.E., and Mrs. Carrington, of Clapham, Surrey.

WEBB JONES—LONG.—On Sept. 12th, at St. Mary Abbots, Kensington, Arthur Webb Jones, F.R.C.S., of Alexandria, to Lilia Bell, younger daughter of the late Captain Wakeman Lon 61st Regiment, and of Mrs. Wakeman Long.

WHITCHURCH—WILLIAMSON.—On Sept. 12th, at the Parish Church of Tempsford, Sandy, John Arnold, son of the late Nathaniel Whitchurch, Esq., M.D., of Melton Mowbray and Great Barford St. Neots, to Norah Madeline Penelope, eldest daughter of the Rev. W. Williamson, Rector of Tempsford.

Deaths.

CATTLIN.—On Sept. 12th, at 4 Westbourne Terrace, Hove, Sussex, William Cattlin, M.R.C.S.E., eldest son of the late W. A. N. Cattlin, P.R.C.S.E., aged 68.

GOODSALL.—On Sept. 14th, at 17 Devonshire Place, London, W., David Henry Goodsall, F.R.C.S., Senior Surgeon Metropolitan Hospital.

GREENWOOD.—On Sept. 10th, from pneumonia, aged 71, Henry B. Greenwood, of 15 Angel Court, London, E.C., and 25 Ladbroke Grove, Holland Park, W., only surviving son of Thomas Greenwood, M.R.C.S.E.

WHITTY.—On Sept. 11th, after a short illness, at Minna Lodge, Hunstanton, Charles Richard Whitty, M.D., second son of the late Rev. David La Touche Whitty, aged 63.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIII. WEDNESDAY, SEPTEMBER 26, 1906. No. 13.

NOTES AND COMMENTS.

Overdosage with Trional.

A CASE presenting some unusual features was investigated by the Clerkenwell Deputy-Coroner the other day. A chemist, the employé of a drug company in Holborn, suffered much from worry, overwork, anxiety and sleeplessness, and was known to be on the habit of taking hypnotics. The matter came to the ears of the company, and the employé was dismissed with a month's salary, but he was promised reinstatement when he could show that he had conquered the drug habit. The unfortunate man went home and locked his door, and when the room was entered he was found asleep with many bottles about him. He remained in bed the next day, and seemed to be improving, for he promised to go to a drug retreat, but he died suddenly on the fifth day. The *post-mortem* showed that he had died of an overdose of trional, but the jury did not find sufficient evidence to bring in a verdict of suicide. On the other hand, the facts are strongly suggestive of such an inference, and if this were really the fact, the instance must be almost unique, for we never remember trional being taken or given with homicidal or suicidal intent. Unluckily it is not stated what quantity of trional was taken, but it must have been very large, as considerable doses have been taken in error without fatal result. Chronic poisoning by sulphonal or trional is now well recognised, but acute suicidal poisoning is not. It is a fact that should be borne in mind now that so many ladies and others take trional habitually, and buy it in tins and tablets in considerable quantities.

Co-operative Quackery.

AN amusing instance of the biter bit has come to our notice through the publication in the *Grocer* of September 15th of an article entitled "Co-operative Substitution." From it we learn that the St. Helens and District United Traders' Profit-Sharing Association are trying to get their members to boycott the ordinary patent medicines and buy similar preparations made by the Association. Now co-operative trading has developed enormously in the last two decades, and as far as the working-classes and lower middle-classes are concerned, it is quite likely that it may become practically universal; in other words, if the co-operative societies can get their members to buy patent medicines from them, the bulk of the money that now finds its way into the pockets of private advertising adventurers will flow into the common pocket of the society. While we deplore the thirst for quack drugs which exists, it must be recognised that it has largely been whetted by the advertisements of the quacks, and one certainly would be glad to hear that if any profit is made out of the sales, it will not go to those who systematically stimulate the morbid tendencies of the public mind.

A Valuable Discovery.

BUT the Co-operative Association have discovered that the prices charged by the manufacturers of quack drugs is enormously over their value, and that it is possible for much smaller prices to turn out just the same goods, and yet handsomely reimburse the sellers. Everyone knows that, as a rule, the price a pharmacist charges for pills and mixtures is considerably more than their actual cost, but this is because the pharmacist's remuneration is partly of the nature of a fee and partly of the nature of payment. Now, a manufacturer who turns out pills by the million for popular consumption has used just the amount of brains necessary to read a prescription in some pharmacopœia and dictate it to a man who can compound it. The fact that a manufacturer charges a high price for his pill is not due to the individual attention that he has bestowed on it, but to the expense he has been at in advertising it in newspapers. So that, now the St. Helens United Traders' Association have discovered this fact, and discovered also how they have been "had" over these patent medicines, they are taking to putting up their own preparations from the same sort of simple formula used by the manufacturers, and we have no doubt the therapeutic effect will be equally happy or unhappy, as the case may be.

Tetanus and the Fourth of July.

THE annual rejoicings which take place in America every Fourth of July have, as usual, been followed by an outbreak of tetanus. It is some satisfaction, however, that the number of cases has during the past few years shown a steady and marked diminution. Thus, in 1903, there were 415 cases recorded as due directly to Fourth of July celebrations, in 1904 there were 105, 104 in 1905, and 89 in the present year. This decrease of tetanus is not coincident with a decrease of total injuries, since during the same period these

have risen in number from 4,449 to 5,466. The decrease is almost certainly due, therefore, to a better care on the part of the profession in the treatment of the class of wounds most likely to give rise to tetanus. In former years tetanus commonly resulted from apparently trivial wounds caused by the explosion in the hand of blank cartridge. It has been impressed upon surgeons that the proper treatment of such cases lies in free exposure to oxygen and drainage. The prophylactic use of antitoxin has also become more common. It is to be noted as bearing out this view that almost all of the eighty-nine persons who suffered from tetanus had received no surgical treatment whatever, whereas in former years the great majority had received superficial treatment. That it is too soon to boast of a bloodless Fourth is evident when we learn that, in addition to seventy-five deaths from tetanus, there were eighty-three from other accidents directly rising out of the national celebration.

LEADING ARTICLE.

THE AWAKENING OF THE GENERAL PRACTITIONER.

THE history of social evolution is that of a slow and gradual process, in which the main inevitable characteristic is progress. So imperceptible is the motion at times that it appears to be stationary, and its existence can be detected only by the most minute and accurate observation. In this quality it may be compared to the infinitely slow progress of an Alpine glacier, or of the frozen sea of ice that surrounds the Northern Pole. With Nature, however, as with man, the end comes at length in obedience to more or less imperfectly recognised laws, no matter how great the delay at the outset. Of all social class evolutions, perhaps that of the medical profession is one of the longest delayed. Compared with other professions, as, for instance, the Church, Law, and the Services, that of Medicine is but a disorganised, neglected, plundered, and ill-rewarded drudge. In spite of its enormous potential powers as a great factor in the community she is politically impotent, and her birthright is practically sacrificed to illegal competitors on every hand. The situation, indeed, would be farcical were it not full of fierce pathos and tragedy on every hand. Parliament has laid down in detail a code of stringent rules for the professional education and examination necessary to medical qualification. Recently those regulations have been rendered more exacting and infinitely more costly by the addition of another year to the curriculum. But while Government, on the one hand, has made provision for the supply of well-educated medical men, on the other it has wholly neglected to furnish any adequate machinery for the exclusion of unqualified quacks, who are allowed to swindle and defraud the public with impunity, and to rob legitimate practitioners of their just fees. Those who practise law have to go through a special curriculum and to pass examinations before being permitted to practise as solicitors or barristers. In the field of actual professional work, however, the lawyers have taken good care to defend themselves against unqualified competition. If an outsider simply writes a letter remotely suggesting he is acting in a legal capacity, he is instantly prosecuted and invariably mulcted in a substantial fine. Yet it is surely just as important to protect the public from quacks who play havoc with life and limb as from petty rogues whose trespasses in legal preserves can result merely in desultory and trivial monetary damage. But the history of medical grievance is a thrice-told tale, and it is a relief to turn to any proposals that may have in them the germ of future reform. After all, the matter chiefly affects the general practitioner, and it will ultimately have to be settled by him. If he demands a really representative General Medical Council, or one-portal system of qualification, and adequate defence against unqualified practice, he will have to secure them with his own right hand. As regards one particular injury, namely, that of unfair hospital competition, we note with satisfaction that he is taking preliminary steps which it may be hoped will not disappear into the limbo of oblivion and futility that has swallowed up so many previous enterprises of a similar nature. The Hospitals Committee of the British Medical Association has addressed a circular letter to medical charities throughout the United Kingdom inviting consideration of a number of points connected with hospital administration. Each institution is invited to send a delegate to a central congress to be held shortly. Should it be found impossible to come to any formal or binding common basis of action, the publicity attached to the proceedings of the congress cannot fail to do good in educating both the public and the medical profession as to the facts of the case. The precise *locus standi* of the Association that asks for the inquiry may create difficulties in some quarters. On the whole, however, it will be wise not to insist too strongly upon a formality of that kind when the request comes from a body that, at any rate, represents a great numerical proportion of the medical practitioners of the United Kingdom. As a matter of plain statement, it appears that the strain of the professional struggle has become intolerable. For our own part, we are inclined to believe that much more benefit would accrue from the suppression of unqualified practice than from the reduction of hospital competition. However now that the Hospitals Committee has laid its hand to the plough, we trust there will be no looking back. Our cordial sympathy and support will be forthcoming whenever any workable scheme is formulated. Meanwhile we ask for general support from the medical profession in our warfare against quacks and quackery. Essentials to success in that campaign will be the reform of the General Medical Council and the appointment of a Royal Commission of inquiry into the whole matter.

NOTES ON CURRENT TOPICS.

Seaside Museums.

The educational value of museums is undoubtedly great if only people can be found to take an intelligent interest in them. Merely to look through a natural history museum affords an object-lesson of unconscious value to the man in the street, while to the serious scientific student such a collection simply becomes the essential complement of his books. At the same time it is to be feared that most of the museums scattered through the kingdom are, to put the matter bluntly, simply cheap pleasure-houses for the million. Even then it is difficult to estimate their suggestive value in popular enlightenment. Mr. Jonathan Hutchinson has made the gospel of local museum teaching peculiarly his own, and is spreading it far and wide with his usual thoroughness. So far as small inland towns and villages are concerned, there can be little doubt as to the good work that can be done in that way. It is not so easy to agree with the distinguished surgeon, however, when he advocates the establishment of natural history collections at seaside places. Visitors to holiday resorts of the kind would be about the last persons in the world to patronise museums. The few seaside collections we recall may be described as dismal, dusty, scrappy and shunned. The field for museums in small inland districts, where the population is less migratory and has to fill up winter as well as summer months, is another matter altogether. In this latter aspect Mr. Hutchinson's views summarise fundamental principles of sub-conscious education that are far from generally recognised.

Meat and Tuberculosis.

The full relation of flesh food to infective disease remains to be worked out. Indeed, it is still denied in certain quarters usually regarded as authoritative that tuberculosis, for instance, is spread by tuberculous meat and milk. From a practical point of view it would obviously be a simple matter of precaution to regard such tainted food as highly suspicious and to exclude it from the public supplies. The ancient Hebrew ritual, which possessed a marvellous insight into practical sanitary measures, rigorously rejected all defective carcases, a measure that is administered to the present day by the Jewish Board of Shechita. An important conference of medical officers of health was recently held in London to consider the question of supplying the public with meat from healthy home-bred cattle and sheep. It was convened by the Agricultural and Industrial Society, and the Secretary of the movement is Mr. D. Tallerman. Most of the speakers seemed to accept the proposition that human tuberculosis could be acquired by eating the flesh of tuberculous animals. The objects of the Society appear to be practical, sound, and of the utmost importance to the national public health. The Secretary pointed out that by using cold storage chambers on a large scale the meat could be dressed, coarse portions of the carcases could be tinned, and that their Society proposed to do such work for farmers, butchers, and grocers at a reasonable remuneration. At the same time the demand for home-bred meat would be greatly increased.

Unclean Medicine Bottles.

The great triumph of modern medicine, as everyone knows, depends on the prevention rather than the cure of disease. Hence the value of bacteriology, which enables the public health expert to put his finger, as it were, upon the evil-working bacillus and so arrive at first causes. His gospel amounts in the long run to the most ancient of teachings, namely, that cleanliness is next to godliness. It is astonishing the number of human maladies that owe their origin to contamination of the gross and readily preventable kind. A glance round at the many diseases arising from pollution of air, water, food, schools, dwellings, and workshops will prove the truth of that statement a thousand times over. Now turn to a particular instance—the medicine bottle. Each bottle should, properly speaking, be sterilised before physic is put into it. The average life of an ordinary dispensary phial, however, is long and full of vicissitudes. Among the latter are the domestic ashpit and the municipal dust-heap, while empty bottles are used for a vast variety of fluids from gin to hair-oil, from furniture polish to materials of unspeakable nature. Many bottles revert to their original use as receptacles for physic, and it is obvious that nothing short of absolute sterilisation by steam at a high temperature can render them safe for such a purpose. The careful medical man who dispenses his own physic has long been alive to this danger.

Distribution of Honours.

In our correspondence columns we publish a letter from a distinguished old Indian medical officer, Surgeon-General Tuson, M.D., F.R.C.S., who writes to us to draw attention to his claim to reward from the Government which he served long and faithfully. We know that the distribution of decorations and rewards is an invidious task for those in authority, but it is unfortunately the fact that merit is not the only factor that counts. Personal friendship is often allowed to decide what should be a purely official question, and preference for individuals in some cases is pushed to a glaring extent. Surgeon-General Tuson feels that he is labouring under a grievance in having his service slighted, and after trying the usual official channels he turns to us. We are sure that nobody could read the record of his services in times of war and peace without feeling that he is a man of the type that has built up our great Indian Empire. Medical officers in India are called upon to undertake duties both medical and military of the most varied character, and Surgeon-General Tuson's

services include fighting in the Mutiny and in the Wuzeeri Campaign, the charge of Simla during the cholera outbreak in 1866–1867, the sanitary charge of the great Durbar in 1876, and the tenure of many important official posts. All that he has done has earned the praise and thanks of his superiors and inferiors, and it seems to us that it would be a gracious act on the part of the Indian Government to bestow a decoration on him at one of the periodical distributions of honours.

Public Compensation for Enteric Fever—Municipal Responsibility.

AFTER the outbreak of typhoid fever at Lincoln a year or so ago, it was proved that a municipality guilty of neglect in safe-guarding its water-supply against pollution might be made responsible for damages to those suffering from illness in consequence. The question of law was not disputed, and the Town Council did in fact pay a large sum in compensation to victims of the epidemic and their relations. A similar sequel is now reported from Basingstoke where a recent outbreak of typhoid was traced to town water-supply. The Borough Council had fifty actions for damages entered against them in the High Court, the total sum claimed being nearly £4,000. In order to avoid litigation a committee of the claimants was formed, and this committee agreed to meet a committee of the Ratepayers' Association to adjust the claims. As a result the Council have agreed to pay £1,760 in settlement of the actions. This payment, we are told, has been made "without prejudice" and with "denial of liability." It is difficult to understand the value of these reservations; they may represent some legal technicality, but the fact remains that the Council have not ventured to fight the question. With the two cases of Lincoln and Basingstoke on record, it is to be hoped that Councils throughout the country, whether rural or urban, will recognise more fully their responsibilities with regard to the water-supply they control. It is satisfactory to add that the Basingstoke authority has now gone to a fresh source for their water.

The Health of Belfast.

MUCH attention has been given in the newspapers of the last few months to questions affecting the health of Belfast. It will be remembered that the Corporation are endeavouring to fix the salary of the Medical Officer of Health at so low a figure as to prevent properly qualified candidates from presenting themselves. At the moment of writing the Corporation and the Local Government Board are at a deadlock, as the latter body has declined to sanction the utterly inadequate salary proposed by the Corporation. It can hardly be maintained that the attitude of the Corporation is due to ignorance of the needs of such a city as Belfast, since they have year after year object lessons provided for them in the shape of epidemics of typhoid fever. This autumn as usual a typhoid epidemic has broken out, and shows no sign of diminution. Belfast, as much as any city in the Kingdom, requires the services of a thoroughly capable and thoroughly trained medical officer of health. It is absurd to expect a practitioner without special training and experience in sanitary work to be able to grapple with problems which require highly specialised knowledge. If the Corporation remain determined to regard the health of the people of Belfast as of no importance, it is to be hoped that the Government will take steps to make their responsibility clear. We understand that the citizens of Belfast intend shortly to hold a public meeting to demand the appointment of a Commission of Inquiry. Such a Commission would do much to direct public opinion to a grave scandal, but its further power would be very limited.

Insanity in Ireland.

THE recently published Blue Book with reference to the increase of insanity in Ireland is an important document. It deals exhaustively with the subject, and presents an authoritative collection of facts and a series of comments and conclusions that form a weighty contribution to the literature of the subject. To discuss this special report within the limits of a paragraph is obviously out of the question. The attention of readers, however, may be drawn to its appearance and we hope to deal with the matter more fully in an early issue. At the same time it may be mentioned that a prominent place is given to the influence of emigration. By draining the country of its strong and healthy members it lowers the general mental and bodily standard and leaves behind many weaklings. A number of the unfit emigrants moreover, return to Ireland. The somewhat disquieting fact is disclosed that insanity is more prevalent among Irish emigrants in America than among those coming from other countries. "Relative to their numbers," says the Report, "the Irish furnish a much larger proportion of the white foreign-born insane than any other nationality." The incessant stress and hurry of American life appears to be peculiarly unsuitable to the emotional Celtic temperament.

India and the Opium Trade.

THE awakening of the East has of late years been proclaimed in startling fashion by Japan. Signs are not wanting that China will sooner or later follow in her wake. Already the Chinese are reforming their educational methods and creating an army trained for modern warfare, not to mention the fact that their Government has recently appointed a Commission to study political economy as applied in Western civilisation. But perhaps the most significant sign of all is that contained in a lately issued edict ordering the abolition of the use of opium within the space of ten years. The average European can only dimly realise the amount of physical and moral degradation inflicted by opium-smoking upon the Chinese nation. By its discontinuance a well-nigh

incalculable drain upon the national physique will be put a stop to. The effect of the edict upon our great Indian dependency will be immediate and considerable. The local revenue derived from the opium trade with China amounts yearly to £4,500,000. The moral responsibility involved, however, in the opinion of many Englishmen far outweighs any compensatory budget advantages. To put the matter bluntly, several costly wars have been waged with China simply and solely to force upon that empire our Indian opium. The Chinese accepted the drug under protest, and later, in self-defence, grew large quantities of opium in their own country. Some idea of the iniquity of the whole proceeding may be gathered from an imaginary picture of China sending several armed expeditions against the United Kingdom, and compelling her to import from the conquerors five millions worth of alcohol. The abolition of the opium trade will remove a blot from the British administration of India.

New York Consumptive Campaign.

The energies of the National Association for the Prevention of Consumption, or rather the financial contributions of its supporters, have of late waned considerably, but there remains the palpable fact that people generally are more alive to the nature of consumption and better primed in the methods for avoiding it than they were ten years ago. Still, our campaigns against tuberculosis are rather one-horsed affairs after all, and it would really be well if the facts about the disease and its prophylaxis reached people more directly than through the medium of a half-torn notice posted on a hoarding or a warning not to spit enamelled on the seat of a 'bus. To our sanitary friends we would commend the example of the Health Department of New York, not perhaps for exact imitation, but at any rate as showing what can be done. An instrument called the stereopticon—a kind of magic lantern—is fixed in the public parks, and from it there are flashed on to screens captivating pictures of tubercle-bacilli and epigrammatic warnings against infection with tuberculosis. These shows are very popular, and large crowds stand every evening gazing at the wonders provided for their delectation, for interspersed with the serious pictures are others of a lighter and more attractive kind. There is no denying that by means such as this a large number of slum dwellers are reached who would not be amenable to education in any other way, and though to the Britisher the plan savours rather of the cheap-jack, it must be remembered that the cheap-jack is the man who caters for and reaches the poor. At any rate it may be taken for granted that it is better for the people to read on illuminated screens at night, "Don't live in a room where there is no fresh air," than that Apple's soap is the best or that Cowine is indispensable for infants.

London Medical Exhibition.

On the first five days of October, Monday to Friday inclusive, will be held the Second London Medical Exhibition at the Royal Horticultural Hall, Vincent Square, London, S.W. Last year's exhibition was one of the most successful gatherings of the kind ever organised. The reason of its popularity in the profession was doubtless due to the fact that invitations were confined to medical men. The hall will be open from 11 a.m. until 6 p.m. daily, and various attractions are provided in the way of a reception-room, light refreshments, and military bands. All medical men who have time and opportunity will do well to visit this Exhibition.

PERSONAL.

It is announced that Sir Victor Horsley has written to the President of the General Medical Council resigning his seat on the Council in order that the inconvenience of a separate election next year may be avoided.

It is stated that Dr. Frederick Taylor, of Guy's Hospital, and Dr. E. G. Graham Little, of St. Mary's are candidates for the vacancy which has arisen through the resignation of Dr. J. F. Payne from the Senate of the University of London.

Professor Ivan Petrovitsch Pawlow, professor of physiology in the University of St. Petersburg, will open the winter session of Charing Cross Hospital Medical School, on Monday, October 1st, and deliver the sixth biennial Huxley lecture, "On Recent Advances in Science and their Bearing on Medicine and Surgery," at 4 p.m. Medical practitioners can obtain cards of admission from the Dean so far as the accommodation permits.

Mr. Robert Mackey Wilson, of Dublin, has presented the sum of £1,000 to the Governing Body of Queen's College, Belfast, for the purpose of instituting a medical travelling prize to be competed for by newly-qualified medical graduates of the College. The prize will be awarded triennially, and will be of the value of one hundred pounds.

Professor Alexander Macalister will distribute the prizes to students of the Faculty of Medicine, at University College, Bristol, on October 2nd.

A Reuter telegram from Rome reports that the illness of Dr. Lapponi, physician to the Pope, has been diagnosed by Dr. Mazzoni as cancer of the stomach.

Dr. Leonard Mark will give the presidential address to the West London Medical Chirurgical Society on Friday evening, Oct. 5th. The subject will be "Art and Medicine," and the address will be illustrated by lantern-slides of some pictures and works of art in British picture galleries and museums, which are interesting from a medical point of view.

Dr. Bergmann is leaving Constantinople, but, at the Sultan's request, Dr. Bier is remaining at the palace to superintend the royal "cure."

On September 19th Dr. Booth was elected medical officer of health to the Cleethorpes U.D.C., in place of the late Dr. T. Newby.

The Lord Mayor presided at the Mansion House at a public meeting held last Thursday at 3 p.m., at which Miss Olga Nethersole gave a short address explaining the details of a Universal Woman's League she is forming, for the purpose of spreading a knowledge of and combatting the ravages of tubercular disease.

A CLINICAL LECTURE
ON
DISEASES AND INJURIES TO THE ORBIT.*

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PART I.

THE orbit is the bony socket in the skull which lodges the eyeball and other structures appertaining to the nourishment and protection of the organ of sight. It is made up of seven bones, namely, the frontal, ethmoid, sphenoid, superior maxilla, malar, lacrymal, and palate. The inner walls of the two orbits, formed by the ethmoid and lacrymal bones, are practically parallel with one another, but the outer walls, formed by the frontal bone and the lesser wing of the sphenoid, diverge considerably. The upper wall, formed by the frontal bone and the lesser wing of the sphenoid, is hollowed from side to side. The lower wall, formed by the malar, superior maxilla, and the palate bone, is concave from side to side and slopes outwards and downwards. In a singular case I saw recently there was a congenital non-differentiation of the lower orbital arch, giving a peculiar and characteristic conformation to the palpebral fissure.

The orifice of the orbit is protected against violence by strong buttresses of bone, belonging to the frontal and malar bones; upon the inner side it is shielded by the prominent nasal bones.

The orbit is lined by periosteum (sometimes called "periorbitum" in this position), continuous behind with the dura mater through the ophthalmic foramen and the sphenoidal fissure, and in front with the orbital septum. The loose attachment of the periosteum to the bone doubtless explains the facility with which hæmorrhage may occur between the two structures, as in injuries or in infantile scurvy.

The orbit has two fissures and seven foramina. The fissures are called respectively the sphenoidal and the spheno-maxillary fissure, and are destined for the transmission of nerves and blood-vessels. The sphenoidal fissure, directed obliquely upwards and outwards, lies between the greater and the lesser wing of the sphenoid bone, and connects the orbit with the middle fossa of the skull. It transmits the third, fourth, ophthalmic division of the fifth, and the sixth nerve, besides filaments of the sympathetic nerve and the ophthalmic vein. The spheno-maxillary fissure is situated in the lower wall, and connects the orbit with the zygomatic fossa. It is bridged over by plain muscular fibres (the orbitalis muscles), corresponding to a more considerable layer found in certain mammalia. It transmits the superior maxillary nerve and the infra-orbital artery. The optic foramen (the only one of any consequence in this place) lies at the apex of the orbit, between the roots of the lesser wing of the sphenoid. It transmits the optic nerve and the ophthalmic artery. It is separated by a thin plate of bone only from the sphenoidal sinus, and the optic nerve is accordingly liable to damage early in the course of tumours affecting that sinus.

Other points of interest about the orbit are (*a*) the fossa for the lacrymal gland situated under cover of the external angular process on the outer side of the orbital plate of the frontal bone; (*b*) the lacrymal groove for the lacrymal sac at the side of the nose near the inner canthus in the lacrymal and superior maxillary bones. It is crossed by an important surgical landmark in the shape of the tendon oculi; (*c*) the supra-orbital notch (or foramen) for transmission of the supra-orbital artery and nerve, lies at the junction of the inner third with the outer two-thirds of the upper margin of the orbit—it can be easily felt in most subjects; (*d*) the pulley for the superior oblique muscle, marked by a tiny bony tubercle, can be felt somewhat behind the supra-orbital notch and the internal angular process of the frontal bone; (*e*) the infra-orbital foramen opens on the anterior surface of the superior maxillary bone, 5mm. to 10mm. below the orbit. It is the termination of the infra-orbital canal, which lies in the floor of the orbit, and which transmits the infra-orbital nerve and artery from the zygomatic fossa to the skin of the face between nose, eye, and upper lip.

The orbit is surrounded by a number of air-sinuses, viz., the frontal, maxillary, ethmoidal, and sphenoidal, together with the nasal cavities. The frontal sinus is a space lying between the two tables of the skull, one on each side of the middle line, behind the nasal eminences of the frontal bone. They are lined by mucous membrane, and are in free communication by the infundibulum with the nasal cavity. They fail to reach any marked development until puberty, and show great individual variations in size and in shape. They are usually separated from one another by a vertical shell of bone, but that may be absent or incomplete, so that there may be one large sinus only. Inflammation of the sinus may be due to injury, but more commonly appears to be secondary to nasal disease. Retention of secretion may be indicated by a bulging near the root of the nose, that is to say, of the orbital plate of the frontal bone. The maxillary antrum, or antrum of Highmore, is a pyramidal cavity, lined with mucous membrane, in the body of the superior maxillary bone. Its orifice communicates with the nasal cavity. It varies in size and shape, but is the largest air-sinus. The roots of the canine or first molar teeth frequently project through the alveolus into the space. Its upper wall forms part of the floor of the orbit, and may be bulged when the antrum is filled with fluid, pus, or a solid growth. Antral disease results from (1) decayed and septic teeth, and (2) nasal inflammation. The ethmoidal and sphenoidal sinuses lie respectively in the ethmoid and the sphenoid bones.

The contents of the orbit include the eyeball, optic nerve, lacrymal gland, ocular muscles, levator palpebræ superioris, nerves, vessels, fasciæ, and granular fat.

The optic nerve enters the orbit through the optic foramen, and takes a curved course to end in the eyeball as the retina. This sigmoid curve of the nerve allows free movements of the eyeball to take place. It accounts for the fact that definite exophthalmos need not necessarily interfere with the conductivity of the nerve. Indeed, exophthalmos, generally speaking, must be pronounced to entail either organic changes in the nerve or mechanical limitation of the ocular movements. A rapidly-produced exophthalmos is much more likely to do mischief than one of gradual development.

The arteries are branches of the ophthalmic, which enters the orbit through the optic foramen. The veins are two in number, one superior and the other inferior. They reach the cavernous sinus by passing between the heads of the external rectus muscle through the sphenoidal fissure. They anastomose with the veins of the forehead, and evidence of this communication may sometimes be found when the cavernous sinus is occluded by a thrombus. The fact

*Delivered July 18th, 1906, in the Post-Graduate Course of Ophthalmology in the University of Oxford.

that the superior ophthalmic veins of the two sides are in free communication, behind by the cavernous, circular, and transverse sinuses, and in front by an anastomosis over the bridge of the nose, has led Motais to suggest (*Recueil des Travaux de Congres International d'Ophtalmologie*, Sept., 1904) that the infection in sympathetic ophthalmitis may travel from one eye to the other by this venous channel.

The central artery of the retina, a branch of the ophthalmic, enters the optic nerve 10mm. to 20mm. behind the eyeball. The central vein emerges from the nerve at the same spot, and runs either directly into the cavernous sinus or first joins the superior ophthalmic vein. This accounts for the distension of the retinal veins seen with the ophthalmoscope when the cavernous sinus is occluded, or when it is placed in morbid communication with the internal carotid artery, as in some cases of pulsating exophthalmos.

The nerves are numerous, and comprise the third, fourth, and sixth cranials, and the first and second branches of the trigeminus. The ophthalmic ganglion, a tiny reddish body, lies at the hinder part of the orbit, between the optic nerve and the external rectus muscle. Its sensory root comes from the fifth, its motor root from the third, and its sympathetic root from the cavernous plexus. The short ciliary nerves ten or so in number, run from the ganglion along the optic nerve to the eyeball.

Before describing as briefly as may be some of the more important diseases of the orbit, a few words may be usefully said with regard to injuries. Injuries of the orbit, which include contusions, fracture of the bones, and penetrating wounds with or without the lodgment of foreign bodies, are not common accidents.

As regards contusions, J. Jameson Evans (*British Medical Journal*, July 8th, 1905) has recently reported a series of cases where a blow upon one external angular process was followed by sudden impairment of sight in the corresponding eye. Additional symptoms were loss of the greater part of the temporal field of vision, and in the course of a few weeks atrophy of the optic papilla. Evans concludes that these symptoms are produced by contusion of the nasal fibres of the optic nerve by *contre-coup*. The opposite side of the nerve is shielded by the ophthalmic artery, which winds round its outer side from below.

A serious injury is dislocation—or, rather, avulsion—of the eyeball. This injury is sometimes self-inflicted by a frenzied maniac, or may be done by an antagonist during the course of a quarrel. Some twenty cases have been known to occur in the course of difficult labour. In most of these latter cases there has co-existed a depression of the cranial bones above the orbit of the affected side, so that Thomson and Buchanan (*Trans. Ophthal. Society*, vol. XXIII., 1903, p. 296) are undoubtedly correct in designating the injury as "extrusion" of the eyeball rather than as "dislocation." As a rule, the injury has been due to forceps, but at least one case is known (*Ophthalmic Review*, July, 1906) where the eye was extruded apparently by uterine contraction alone. In a celebrated case quoted by De Wecker (*Annales d'Oculistique*, 1896, T. CXVI., p. 40) an accoucheur mistaking a face for a buttock presentation, managed to gouge out the baby's eye with his finger. Another similar case is on record.

Division of the trunk of the optic nerve may be another consequence of penetrating wounds of the orbit. Blindness will be the immediate and optic atrophy the remote result of such an accident. A case of this kind was mentioned by the late George Lawson in his "Injuries of the Eye, Orbit, and Eyelids" (1867). A clergyman, while shooting, stooped quickly to pick up a bird that had fallen among some bulrushes. He felt a sharp pain in one eye, and found that he had lost the sight of that eye. About a month after receipt of the injury, the patient discovered a small hard lump projecting from beneath the eyeball. He pulled at the lump, and was astonished to find that he had drawn from his orbit the head of a bulrush about 1½ inches in length. Cases are known where both optic nerves have been divided by a bullet passing across the orbit on each side.

Some truly remarkable cases have been reported in which foreign bodies have become lodged in the orbit, often without the patient having any suspicion of the nature of the injury. What is perhaps the leading case of this description was recorded by Brudenell Carter many years ago. An iron hat-peg, upwards of three inches in length and weighing twenty-five scruples, lay impacted in the orbit for several days without the patient's knowledge. The man, whilst intoxicated, had fallen down some stairs against the peg, which had penetrated the tissues of the orbit and broken off short. Another famous case was that of Nélaton, who, three years after an injury, removed from the orbit of a young man the ivory handle of an umbrella 1⅛ inches in length.

Blindness following injuries to the orbit or skull are now known to be due to fracture of the roof of the orbit and optic foramen, and not to reflex influence, as the earlier writers assumed. Hölder and Berlin have shown that a fracture of the base may be complicated with fissures in the orbit, and in that way may produce loss of sight. Deep conjunctival ecchymosis and, later, atrophy of the optic disc are likely to be met with in such cases. Then, as already stated, *contre-coup* may account for some of the cases.

Some attention has lately been paid, especially by Nettleship (*Trans. Ophthal. Society*, Vol. XXI., 1901, p. 102) to what have been termed "indirect gunshot injuries" as affecting the eye. In these cases the passage of a bullet through the orbit is followed at once by bleeding into the vitreous, and when the hæmorrhage clears up, serious lesions are found in the eye. It is important to note that in these cases the eyeball has not been directly injured by the projectile. These curious injuries (believed to be due to intense tissue vibrations set up by the bullet impinging upon the eyeball and damaging its contents) may entail complete blindness. They are mentioned here because they may be confused with instances in which the optic nerve or nerves have been cut across by a shot. Indeed, in some of the cases mentioned by Nettleship there was reason for thinking that the two conditions were combined.

The diseases of the orbit may be divided into two primary classes:—(1) Inflammatory; and (2) non-inflammatory affections.

(1) Inflammatory affections are marked by pain, redness and swelling of the eyelids, accompanied, as a rule, by exophthalmos, limitation of the movements of the eyeball, and fever. They include periostitis, cellulitis, tenonitis, and thrombosis of the cavernous sinus.

The symptoms of periostitis differ according to the position of the inflamed part, whether superficial or deep. In the common form, where the rim of the orbit is involved, there is no disturbance of the general health worth mentioning. The symptoms are purely local, and include deformity and swelling, tenderness, pain, some œdema of the corresponding eyelid, and, perhaps, partial chemosis of the ocular conjunctiva. The process often undergoes complete revolution. It may, however, lead to the local development of osseous deposits or of pus. After the abscess has burst or been opened, a fistula will remain, through which roughened bone may be felt with a surgical probe. Such fistulæ or sinuses, more correctly, which are far from uncommon in tuberculous children, are generally placed at the lower and outer edge of the orbit, probably because that spot is more subject to contusions than others. They often entail eversion of the affected eyelid (ectropion).

On the other hand, let us suppose that inflammation has attacked the periosteum in the depths of the orbit. The symptoms in that case will be intensified. Thus, there will be deep-seated pain, more or less fever, and general malaise, redness and swelling of the eyelids, chemosis of the conjunctiva, and protrusion of the eyeball, with limitation of movement. As regards

the last two signs, it may be noted that (*a*) the eyeball, as a rule, is displaced away from the lesion, and (*b*) restriction of movement is directly proportional to the degree of exophthalmos, since it is mainly due to stretching of the recti muscles and optic nerve.

Should a deep-seated abscess form, it may be impossible to distinguish the condition from cellulitis. Tenderness of the rim of the orbit is believed by some to indicate periostitis as opposed to cellulitis, but I should not myself be inclined to lay much stress on that point. The common causes of periostitis are tubercle, syphilis, infection, and injury. In children, suspect tuberculosis; in adults, syphilis.

Inflammation of the cellular tissue of the orbit, or cellulitis, may follow injuries or operations, or it may occur as a complication of erysipelas, pyæmia, or specific fevers, or it may be produced by extension from neighbouring parts, as the ethmoidal or sphenoidal cells, the nasal cavity, or the antrum of Highmore. The cause, however, is sometimes quite obscure. This serious malady may prove fatal from extension to the cranial cavity.

There is much dusky swelling of the eyelids; the side of the face is puffy, chemosis is present; the eyeball is thrust markedly forwards, and its movements are impaired or altogether lost. Vision, according to the state of the optic nerve, may or may not be affected. There is severe pain, especially in the orbital region. Fever and headache are always present, and the patient is often seriously ill. The symptoms may subside, but usually go on to the formation of pus, orbital abscess. If the collection be not evacuated surgically the pus will sooner or later burst through the conjunctiva or the skin of the eyelids. Extension to the brain will be indicated by the advent of cerebral symptoms—as, for example, violent headache, rigors, vomiting, slow pulse, and mental hebetude. Thrombosis of the orbital veins is probably present in all severe cases.

Cellulitis as it occurs in very young children deserves a word of passing mention. The affection is rare, if we may judge from the fact that it is scarcely alluded to in literature, although Leplat (*Annales d'Oculistique*, January, 1898) described a case in an infant of fifteen days, and Trousseau (*Bull. et Mem. de la Société Française d'Ophtalmologie*, 1898, p. 57) two such cases in children, æt. respectively 9 weeks and 9 months. In one of Trousseau's patients the cornea perforated five days after evacuation of the orbital abscess. They all terminated favourably. The etiology of the disease as it occurs in infants is obscure. I venture to suggest, however, that it may be due to infection gaining the orbit by means of the pituitary mucous membrane, inoculated with pyogenic microorganisms from the mother's genital tract during or immediately after the act of birth. The fact is not without significance that in two of my patients coryza coincided with cellulitis.

In older children, I believe, a so-called cellulitis is generally only a manifestation of a process akin to if not actually identical with infective ostitis (acute necrosis).

The capsule of tenon is a layer of fascia surrounding the greater part of the eyeball, so as to favour free movement. Behind, it blends with the sclera at the point where the ciliary vessels and nerve enter the eyeball, and in front it is attached to the limbus of the cornea. Its processes invest the several muscles inserted into the sclerotic coat, while extensions of the fascia to the walls of the orbit, known as "check ligaments," help to keep the eyeball in position. The capsule is lined with endothelial cells, and is, in fact, a lymph space.

Primary tenonitis is extremely rare, but may result from septic infection, as after squint operations, or as a sequel to some specific ailment, as rheumatism, gonorrhœa, or influenza. The capsule may become inflamed as a complication of existing eye disease, as panophthalmitis. The symptoms include redness and swelling of the eyelids, chemosis, and slight exophthalmos. The movements of the eyeball are more or less hampered, and cause distress. The disease may terminate in resolution or in suppuration, and Jocqs (*La Clinique Ophtalmologique*, May 25th, 1905) has reported a case where the latter event ended in death.

As tenonitis is an uncommon disease, I may give brief details of a case recently under my care. A man, æt. 47, was seen by me at the Kensington General Hospital on March 14th last, complaining that both his eyes had been inflamed for two days. He had been feeling poorly for about a fortnight. Upon examination there was marked fleshy chemosis of the lower half of each eyeball, the upper half being merely reddened and not much swollen. The œdematous ocular conjunctiva projected from between the eyelids, so as to form a conspicuous, red, and unsightly mass. Movements of the globe were somewhat restricted and uncomfortable. Corneæ bright and clear; pupils equal and active. No discharge present. Tension normal. Three days later the ocular condition was considerably improved, but the patient was clearly suffering from an attack of influenza, probably in the nature of a relapse. The man made a good recovery.

A definite history of infection and the milder symptoms should serve to distinguish tenonitis from periostitis or cellulitis of the orbit. Although not a primary disease of the orbit, yet thrombosis of the cavernous sinus may be mentioned here, since it is likely to be confused with cellulitis. It is exceedingly rare and generally fatal. It may be due either to simple or to infective thrombi. Its commonest cause appears to be septic foci about the face, caries of the petrous bone, fractures of the skull, orbital cellulitis, or erysipelas. It differs from any of the diseases so far described in the fact that it tends in most cases to affect both eyes, not simultaneously, but one after the other, by spread through the intercavernous sinus. It is marked by serious cerebral symptoms—as headache, delirium, vomiting, and stupor, and by local signs, of which the more important are swelling of the lids and conjunctiva, exophthalmos, limitation of movement, paralysis of the third or of other cranial nerves passing through the sinus, marked distension of the retinal veins, and pain in the first division of the fifth nerve, as evidenced by intense frontal headache and neuralgia. A painful œdema in the mastoid region (Greisinger's sign) is sometimes present, and is due to interference with the circulation through the occipital veins. To sum up, this affection presents four somewhat characteristic signs:—(1) It tends sooner or later to become bilateral; (2) it is associated with marked distension of the retinal veins, and possibly with thrombosis; (3) it may be accompanied by œdema in the region of the mastoid process; and (4) it is now and then associated with enlargement of the frontal veins, due to the blood passing through the orbito-facial anastomosis.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week's number will be by Sydney Stephenson, M.B.Ed., F.R.C.S., Ophthalmic Surgeon to the Evelina Hospital, the North-Eastern Hospital for Children, and Queen Charlotte's Lying-In Hospital, on "Diseases and Injuries of the Orbit." Part II. Lecture delivered in the University of Oxford on July 18th, 1906.*

ORIGINAL PAPERS.

MEASLES AND ITS PREVENTION.

By JOHN C. THRESH, D.Sc., M.D., D.P.H.,

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Measles affects the sexes about equally, and no age, however advanced, affords complete protection. Infants have been born with the disease developed, and aged people on occasions have been attacked. Where the

disease has been imported into communities which have hitherto been free, or at least not affected for a generation, people at all ages were attacked and often the mortality has been frightful. In countries where the disease is always more or less prevalent adults are rarely attacked, simply because so large a proportion have suffered from the disease in infancy, and one attack affords such complete protection that a second attack is practically unknown. Children aged between 2 and 5 years appear to be most prone to infection, but the disease is most fatal to children under 2 years. Sixty per cent. of the deaths which occur from measles are of children under 2 years of age, 30 per cent. of children between 2 and 5 years, 8 per cent. of children between 5 and 10 years, leaving only 2 per cent. for children and others over 10.

Measles has a tendency to occur in epidemics. These are especially marked in large urban communities and occur at intervals of two to three years. This periodicity is not so well marked in rural communities. In large towns the disease is always present, the maximum number of cases occurring about Christmas. There is then a rapid decline until February, when an increase again occurs and continues until June. Again there is a decrease which continues to September, when the minimum is reached, followed by a more rapid increase to the maximum in December.

In country districts this seasonal curve is not followed. Usually the disease becomes epidemic in a parish and then entirely disappears therefrom. The infection may spread to adjoining parishes, where the same phenomena are observed. The danger of an epidemic outburst therefore is greatest when the disease is introduced into a parish from which it has been absent two or three years, and especially if it is introduced in the autumn or early summer, when for some reason it has a greater tendency to spread.

In some outbreaks the disease appears to be of a mild type, in others severe. For example, in 1904, when measles was notifiable in certain districts in the county, 1,010 cases were notified in Colchester with 29 deaths, or about 1 death per 35 children attacked. In Ilford there were 805 cases notified and only 5 deaths, or 1 death per 161 children attacked. This variation in fatality I shall have to refer to later.

Measles is not known to have any relation to soil. It does not appear to be transmitted by drinking water, or by milk or any article of food. Nor does it appear to be related to any disease occurring in animals which might be transmissible to man. The infection is probably on occasions carried by articles of clothing and other fomites, but the only manner in which it is usually conveyed is from person to person by inhalation. The infective matter, probably a micro-organism not yet isolated, is given off by the breath and from the discharges from the mouth, nose and eyes, and it is of the utmost importance to note that a patient is infectious from the earliest onset of the disease, certainly for some days prior to the attack being so far developed as to render its diagnosis certain. For 12 to 14 days after becoming infected the patient appears quite well, then he exhibits all the symptoms of a common cold, he is feverish, and there is "running" of the nose and eyes. On the fourth day from the onset of these symptoms the rash appears, usually first showing on the forehead. Some days later the rash fades and is often followed by a "branny" desquamation. These branny scales are usually regarded as "infective," but the proof of this is far from conclusive, but a patient cannot be considered free from infection until the desquamation is complete, or until three weeks have elapsed from the appearance of the rash.

The most dangerous and most fatal complication, especially liable to occur if the patient is not properly nursed and tended, is broncho-pneumonia (inflammation of the lungs and bronchial tubes), and it is this complication which is chiefly responsible for the deaths following measles. If recovery occurs the lungs may be permanently damaged, and the patient at a later date fall a victim to tuberculosis (consumption).

From what has been said it is obvious, I think, that the extent and severity of the disease depends upon three factors: (1) The virulence of the infecting agent, (2) the physical and general well-being of the children, and (3) the sanitary condition of their environment. With reference to the first, the virulence of the infecting agent, I need say very little, as at present it is beyond our control. There are those who deny that there is any variation in virulence, but this I cannot believe. I do not see how we can explain a fatality of 3 per cent. amongst the children in Colchester during 1904, with a fatality of much less than 1 per cent. in Ilford in the same year. I will admit that from my knowledge of the two towns I should have expected a lower mortality in Ilford than in Colchester, but the conditions of the people in the two towns do not vary to such an extent as to explain this great difference.

The physical well-being of the children and their bodily condition are important factors. If a large proportion of the children have been rendered immune by an attack, the risk of the disease becoming epidemic is diminished. If they are in robust health and well and properly fed, and kept in a condition of cleanliness and have acquired clean habits, they are less likely to be attacked, and if attacked the disease is less likely to be severe. It is a fact, observed by all medical men of experience, that measles is far more fatal amongst the children of the poor than amongst the children of the well-to-do (or of the better educated class). This is in part due to the causes just described, but also to the third factor remaining to be considered, the environment. By this I mean the sanitary condition of the dwellings and of the parish, and other conditions due to the care and attention or ignorance and neglect of parents. Dirt, squalor, overcrowding of people in houses, and of houses on space, all tend to facilitate the spread of infection and to increase the severity of the disease. Want of isolation, lack of nursing, inattention to the child, especially when the first symptoms are observed and when it is becoming convalescent, the outcome of ignorance and neglect, are even more important, possibly they are the most important factors in the production of epidemics and in increasing the fatality. It is also the carelessness or ignorance on the part of parents which is usually the cause of the introduction of the infection into schools, the children being sent to school when they ought to be under supervision at home. When infective children have been allowed to attend school (day school or Sunday school) an epidemic is inevitable unless the majority of the children have been rendered immune during a recent outbreak. Finally, parents generally still regard measles as a trivial affection, and can with difficulty be persuaded to take the necessary steps to guard against the spread of infection.

From what has been already said it will be obvious that there are special difficulties to be contended with in dealing with measles. The chief are (1) the extreme infectiousness in the early stages before the true nature of the disease is obvious, (2) the difficulty of obtaining early notification of cases, and (3) the ignorance and apathy of parents.

What steps can be taken under the circumstances to control the disease? And, more particularly, what are the measures which can be taken by the sanitary authorities? These can be considered under three heads:—

1. The obtaining of early information of cases occurring in the district.

2. Measures which may be taken to prevent extension of the infection in the houses invaded.

3. Measures for checking the spread from house to house or from family to family throughout the invaded district.

Taking these in order, we have first to consider how best to obtain an early intimation of the presence of measles, and naturally the question of making the disease compulsorily notifiable under the Infectious Diseases Notification Act suggests itself. This has been tried in very many districts, and in almost every

case it has, finally, been abandoned. Amongst the poor a medical man is rarely called in to treat a case of measles, unless at a late stage, when some serious complication has occurred, and the parents, whose duty it would be to notify, always plead ignorance, alleging that they thought the disease was German measles, nettle rash, teething rash, or something of this kind, and, as it is rarely possible to prove that they knew the disease to be measles, the Act becomes, practically, a dead letter. Moreover, Sanitary Authorities, finding that compulsory notification is very expensive and has apparently little effect in reducing the prevalence of the disease, are not anxious to prolong the experiment.

More important than the mere notification of the majority of cases, which is what compulsory notification effects, is the notification of the very earliest case or cases which occur in a district (I now more particularly refer to rural districts, where the disease often disappears entirely for a time), and of the fresh houses invaded. The persons most likely to hear of such cases are, not the medical practitioner, but the schoolmaster, the school Attendance Officer, the district visitor or parish nurse, and the clergyman or minister of the parish. As measles is a disease of great importance to the Education Authority, it appears to me to be very desirable from the educational point of view that they should obtain early information with reference to the introduction of the disease into any parish, and that the Attendance Officer, if instructed to make the necessary inquiries, would be best able to obtain the information required. If he were instructed to make such inquiries, and received a small fee for each family notified, probably this would answer every purpose. I am of opinion that in the course of time there will have to be a medical officer appointed to every school or group of schools, and that the attendance officers will have to make more full and careful inquiries, not merely as to the cause of absence of children, but as to the conditions likely to cause the absence of children, such as the presence of measles, whooping cough, mumps, &c., and that these reports will have to be submitted, weekly or more frequently, to the medical officer. At present I merely suggest for consideration whether the Attendance Officer's services could not be utilised in some way. Failing this we must fall back upon the schoolmaster and schoolmistress, and with the approval of the school authorities, contrive to get them to notify any suspicious case which comes to their knowledge.

Voluntary notification by parents might also be encouraged, but I fail to see how this can be done. If hand bills are distributed during periods when measles is not prevalent, people take no interest in them, and if distributed during an epidemic they are of very little good. The best time to distribute them would be when the disease has first been introduced, in the hope that the people would be inclined to make some little effort to prevent their own households being invaded. This has been done in some districts for years past, and probably some good has resulted therefrom. One clergyman, who thoroughly approves of the attempt to instruct the people by means of leaflets, thinks that there is more information given on them than the people care to acquire, and that less matter and larger type would ensure their being more widely read and the suggestions given being more generally acted upon.

Information having been obtained of early cases, the medical officer and inspector can give advice to parents in the infected households and by frequently visiting endeavour to secure the advice being acted upon. Children from infected families are then excluded from school, and on occasions children who have been in contact with infected persons may be excluded until it is certain that they have not been infected. The medical officer or inspector can also make enquiries as to the source of infection, a course which often results in the discovery of previously unsuspected cases, the very cases which, if not detected, continue to spread infection. This search for mild cases of infectious disease is of the very greatest importance, and I believe that money spent in such investigations and in watching over infected families would do far more good than many times the amount spent in providing isolation accommodation. Of course the ideal condition is the thorough search for mild cases, and the isolation of all infectious cases, but as both are usually impossible I lay greater stress on the former, as without this the isolation of the well-marked cases only cannot be of much if any benefit, and certainly is costly.

For the prevention of the spread of infection in the family and in the community, it has been suggested that hospital accommodation should be provided for cases which occur in houses in which isolation at home is impossible. The provision of a larger proportion of houses with three bedrooms would markedly diminish the number of these cases. Experience with other diseases has not been sufficiently encouraging for me to recommend hospital isolation, especially as such isolation is less likely to be beneficial in case of measles than in cases of scarlet fever and diphtheria, since the disease is infectious at a much earlier stage, and in the majority of cases the infection would have spread in a household before the disease was sufficiently developed to justify removal of the patient to a hospital. We must, therefore, at present be content with enforcing the isolation of patients, as far as practicable, in their own homes. This means constant supervision by the officials. Measles should be considered a dangerous infectious disorder under the Public Health Act, Sec. 126, and parents warned that if they do anything tending to spread infection they will be liable to a penalty of £5. This raises the question whether a disease which is not compulsorily notifiable can be held to be a dangerous infectious disease under this section. This question is really one for the magistrates to decide.

The infected children should remain isolated on the infected premises until the medical officer certifies that they are free from infection, and this raises another important question, viz., can they be considered free from infection unless their clothing and the house generally has been disinfected? To disinfect after every case of measles would involve a large amount of extra work and a considerable expenditure, and I have grave doubts whether the expense would be commensurate with the results if the process were carried out as a matter of routine. I do think, however, that it would be well to insist on thorough disinfection in sporadic cases, that is, in the odd cases which occur when there is no epidemic prevalence. It would probably tend to prevent such epidemic prevalence and be worth trying.

The attendance of children at day and Sunday schools and of persons from infected families at public gatherings also requires attention. All children from an infected house should be excluded from day and Sunday schools, and notice to this effect should be given both to the parents and the school authorities. School closure is only justified when it becomes obvious that the infection is being spread by school attendance. and that all other means of arresting the spread are likely to prove unavailing. Unfortunately the exclusion of scholars entails a serious loss of grant to a school, and this injustice should be remedied. It is a matter, however, which concerns the Education Authority far more than the Sanitary Authority and may safely be left to them.

When schools have been invaded and subsequently closed, the opportunity should be taken to thoroughly clean down the school premises, and the disinfection of the walls, roofs, floors, desks, &c., by a powerful germicidal solution is desirable. Probably also the books &c., could be submitted to some process of disinfection.

Persons from infected houses should not attend public gatherings, especially if children are likely also to be present. This can only be brought about by moral suasion. I am afraid we cannot legally enforce such abstinence.

In certain cases it might be desirable thar a person

should be restrained from continuing his or her occupation, but there is no legal power to enforce this. A woman carrying on the business of a dressmaker cannot be compelled to cease her avocation, and washing may be taken in at an infected house. Scarlet fever and small-pox alone are mentioned under the Factories and Workshop Acts, but if measles is considered a dangerous infectious disorder under the Public Health Act, probably Sec. 126 could be so interpreted as to enable us to prevent the sending out of clothing from infected premises. The authority in such cases should have power to pay compensation.

The disease may possibly also be spread by books from a public library, and where such libraries exist the librarian should be notified so that he neither gives out to nor receives from an infected house any book until the premises have been certified free from infection, and any book which has been on such premises should be destroyed or disinfected.

The taking of all the above precautions means an efficient sanitary staff, sufficiently large to discharge all these duties during ordinary times, supplemented, if necessary, by temporary additions during epidemic periods.

In conclusion, I must observe that all the efforts of the sanitary authority must be more or less futile unless the apathy and ignorance of the people can be overcome. With the present generation possibly little can be done, but I think that a most important factor is the provision of district nurses, nurses living and working in our villages among the people, gaining their confidence, helping them in their affliction, and capable of advising them not only how to nurse the sick but how to prevent sickness. Such nurses are at work in a great many parishes, and no doubt in time one will be found in every parish, and their services will lighten the work of the sanitary inspector and of the medical officer. For the coming generation our hopes must rest upon the efforts of the education authorities. If children are taught the value of health, and how to maintain it, the knowledge must be of use to them in after life, and the next generation may come to regard all infectious diseases as more or less preventable, and may be more inclined to listen to advice given to them, and to co-operate more cordially with the sanitary authority and their officers in their efforts to improve the sanitary condition of their district, and to reduce the incidence of disease.

NOTES ON THE REPEATED IODINE DRESSING IN PUERPERAL INFECTIONS.

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In March, 1904, I brought before the Medica Society of Algiers the results obtained by me in the treatment of eleven cases of puerperal infection by means of the repeated iodine dressing. I may recall that this dressing comprises the introduction into the uterine cavity. previously curetted if necessary, of strips of gauze of suitable dimensions, steeped in a 4 per cent. aqueous solution of iodine. These results were extremely satisfactory, for the patients thus treated were all gravely infected, some were suffering from endometritis with fœtid lochia, and false membranes on the cervix, vulva, or vagina, a high temperature and a rapid pulse; others presented the classic clinical symptoms of incipient septicæmia or pelviperitonitis. Yet all of them made rapid recovery. I drew certain conclusions from my observations—viz., (1) that the dressing might safely be re-applied several times to the infected uterus; (2) that it should be applied twice daily to obtain the best results and to bring back the temperature and the pulse to normal (*a*); (3) that its repeated application promptly arrests the further progress of suppurative puerperal endometritis, and (4) that it may be relied upon to check even advanced cases of endometritis as well as commencing septicæmia; that it is valueless in generalised peritonitis but may render service in subacute pelviperitonitis with plastic tendencies and in cases of septicæmia, by removing the original source of infection.

Since the publication of these notes the results of the method of treatment introduced by Bonnaire have confirmed my views. Bonnaire applies a swab steeped in iodine solution to the interior of the infected uterus (1) when perchloride injections have failed to arrest the progress of the infection; (2) as a preliminary to curetting the uterus, in which case, in order to avert the temporary rise of temperature consequent upon the absorption of infective products disturbed by the curette, the so-called uterine reinfection, the iodine solution is applied three hours before the intervention.

The perusal of the cases set forth in Aumond's thesis (*b*) convinces one of the value of iodine as a local application in infected conditions of the uterus, although the cases he mentions are, it is true, for the most part of moderate severity. In severe cases of infection I hold that swabbing out the cavity with iodine is not sufficient to bring about recovery, and for this reason I still adhere to the periodical dressing as in the past, except that I make an iodine injection before carrying out the preliminary curettage. I am enabled to place on record three other cases of successful treatment and to complete my notes of one of the previous cases.

Case I.—This is a case of puerperal infection already mentioned in my previous communication. The patient had been delivered a week previously by a midwife who had already infected five other parturients. After five days' high fever (38° to 40° C.) she was seized with a severe rigor that lasted twenty minutes. She presented the characteristic facies of infection. The cervix was grey and bathed in pus. In dressing her we removed about half-a-tumbler of blood-stained pus. Three dressings were applied in two days after the curettage, when the fever fell and the pulse became normal. This is an instance of grave infection rapidly arrested in its course. The patient was cured after three dressings followed by irrigations of boiled water.

Case II.—Mrs. X., æt. 28, primipara, was delivered after a normal labour on December 1st. A week later she developed symptoms of infection, pulse 130, temperature 38·5° C. The uterus was enlarged and tender and pus escaped from the cervix. The iodine dressing was applied thrice, and as the uterine discharge persisted I curetted the uterus on the 10th, after which three more dressings were applied. On the 12th the temperature had fallen to 37·9° C., and the uterus was merely washed out. On the 13th the pulse rose to 120 and the temperature to 38·4° C, but matters returned to normal after three more dressings. The uterus was merely washed out daily until the 17th, when a slight recrudescence of the symptoms led to two more dressings being introduced, after which there was no return of the fever although some ten more dressings had to be employed before the obstinate uterine discharge was finally arrested. This case shows that a short period of iodine dressing is not sufficient to do more than afford temporary relief, and that to obtain permanent results the dressings must be repeated; also that iodine injections are quite inadequate. It will be noted that twenty dressings had to be employed to stop an obstinate uterine discharge and that these gave rise to no constitutional disturbance.

Case III.—Mrs. X., primipara, æt. 18, delivered May 23rd, 1905. When first seen she was lying on a pile of soil-stained sacks. The vulva, etc., was carefully cleansed and after delivery the uterus was washed out with a weak solution of phenosalyl. The perineum was ruptured. The same evening the pulse rate was 120 and the temperature 38·4° C. On the following day the symptoms pointed to acute infection extending from the vulva to the endometrium. Pulse 130, temperature 39°. The complexion was ashen and she

(*a*) *Bulletin Medical de l'Algerie*, pp. 185, 1904.

(*b*) Aumond: De l'iode comme opique tuterine dans les infections puerperales. Paris: Thesis, April, 1904.

had several severe rigors, with occasional vomiting and diarrhœa. The abdomen was tympanitic. From the vulva wound, which was covered with exudation, inflamed lymphatics were seen ramifying on the inner side of the thighs and the left buttocks. The cervix was covered with false membranes. The vulval wound was cleansed with oxygenised water and the uterus packed lightly with iodized gauze; later on the uterus cavity was curetted. Seven dressings in four days sufficed to arrest the course of the infection and bring about complete defervescence. After the fifth day only irrigations with boiled water were employed.

CASE IV.—Madame C.M., primipara, normal labour. Five days later the temperature rose to 39·4° with a pulse of 100. The patient, who felt very weak, had had two severe rigors with vomiting and diarrhœa. The belly was distended. The cervix was covered with false membranes and the lochia were very fœtid. In spite of two perchloride irrigations the temperature on the following day was still high, so I curetted the uterus, removing some decomposing placental *debris*. This was followed by the introduction of gauze steeped in a 4 per cent. iodine solution. After six dressings the general condition had improved, although the pulse was still 100. It was decided, however, to substitute injections of perchloride solution experimentally. Three days later the pulse and temperature suddenly went up and the patient complained of sharp pain in the right iliac fossa. The dressings were resumed for the following five days, when the infection was evidently arrested. In this instance the injections of Larnier's fluid were deliberately substituted in order to prove the superiority of the iodine dressings and the result unquestionably proved this superiority. Some fifteen dressings were required in all but a less number would doubtless have sufficed had they been continuous.

These further cases fully confirm the deductions drawn from my first series of observations—viz., (1) The iodised dressing is a sure and powerful means of combatting puerperal infection. The superiority of the iodine dressing over mere injections is obvious and the rapidity of its action is often manifested by an improvement in grave cases within a few hours. The cardinal symptoms of infection usually subside within three days and the general condition correspondingly improves. The final cure is obtained more slowly and after a variable lapse of time. The dressing is particularly efficacious when there is purulent or fœtid endometritis, and our results have been equally satisfactory in several cases of incipient septicæmia. It proved of no avail in a case of acute peritonitis following abortion recently under my care; (2) the dressing is absolutely innocuous, for never in the course of the infections have we ever seen any symptoms of intoxication. Some of the patients had as many as fifteen to twenty dressings without any apparent inconvenience.

Among the earlier patients, going back from one to two years, none has suffered from any deformity of the cervix or stenosis and in none has there been any persistent metritis. The menstrual periods have returned normally and were unattended by pain. Two of the patients have since been delivered at term after subsequent pregnancies.

THE ANTI-MALARIAL CAMPAIGN IN GREECE. (a)

BY MAJOR RONALD ROSS, C.B., F.R.C.S.,
Professor of Tropical Medicine, University of Liverpool.

PROFESSOR ROSS said the question of malaria in Greece was a subject which the Liverpool School would, he thought, take up with that keenness it had shown in connection with malaria in other parts of the world. At the beginning of the year the Lake Copais Company asked that someone should be sent out from this country to deal with the question of malaria in Greece, and he (the speaker) was sent. He went there last May, and studied malaria in the region of Lake Copais. He found the conditions were very serious. The country of Greece was a small one, about the size of the Highlands, but it was there that civilisation began, and from the Acropolis one could see the birthplace of many a movement which had benefited humanity. Therefore, it was a country dear to everyone in Europe and America—they were practically all the children of Greece, intellectually, if not by birth. The population of the country was but 2½ millions, and it was a country of mountains with valleys in between, in which valleys the population was concentrated. In the course of his investigations in the neighbourhood of Lake Copais he visited many of the schools and found evidences of malaria in many of the children in their spleen and in their blood (by pricking their fingers); the disease was very much in evidence, in fact. Out of 80 children examined at one place 38 were found to have enlargement of the spleen: in another place 13 out of 40, and in yet another 25 out of 50. In Thebes itself he only found such evidence in one out of every fifteen examined, which showed a great degree of malaria. He found the parasite in children with the greatest ease, and it was pitiable to see so many weakly children from this cause. Out of the population of 2½ millions there were last year, when there was an epidemic, no fewer than 960,000 cases—nearly one million—while the deaths numbered nearly 6,000. On an average there were, roughly speaking, last year one in every five persons who suffered from the disease. They would, therefore, see how serious was the case of Greece. The deaths were about one in 410 persons last year In this country, where children suffered greatly from measles and scarlatina, they had no conception of the state of affairs in Greece, for, whereas a child usually had the measles only once, a child in Greece might have malaria not once, but twenty times, and suffer week after week, and month after month. This would give some idea of the mischief done by this disease in these beautiful valleys. Speaking from his experience in many parts of the world, he said that malaria was a terrible scourge in any country. Italy had suffered very greatly from malaria, but in the Campagna much good had been done by the adoption of anti-malarial measures. In Greece rural life was almost smothered out, and the country had long suffered. He thought the disease was brought into the country about the time of Pericles, when the conquering Greeks brought home captives from Asia, and he would not be surprised if it were found that the spread of the disease had not a very great deal to do with checking the progress of Greece. Disease might also be found to have much more to do with the decay of other nations than they imagined—it might be the reason that the civilisation of Greece had fallen behind at a certain epoch. Malaria was first studied in Greece 2,000 years ago, and the fact that mosquitoes carried the disease was the outcome of the researches of scientific men during this long period. Therefore, they owed it to Greece to try to do something to help in the

(a) Short abstract of address delivered in Liverpool, September 17th, 1906.

extirpation of malaria there. The Anti-Malaria Society of Greece had attempted to grapple with this question in the one-and-a-half years it had been founded. They owed its inception to Dr. Savas, but the amount of money they had got was not sufficient to enable them to push the work with vigour. They had, however, ascertained the extent of the disease, and had mapped the country in which it occurred and where mosquitoes bred. They had issued pamphlets warning the people against the mosquito, which carried the disease. It was now the duty, he considered, of the Government of the country to drain the areas where the mosquito bred, and the Society would bring this fact under the notice of the Government.

THE OUT-PATIENTS' ROOM.

ROYAL EAR HOSPITAL.

Usefulness of Ossiculectomy.

By Macleod Yearsley, F.R.C.S.

A woman, æt. 34, reported herself some 18 months after operation. The history of the case was as follows:—For about 4 years she had suffered from recurrent attacks of pain and discharge in the right ear, with slight deafness, the first onset being due to "cold." The discharge had been permanent before relief was sought. When first seen, a large posterior perforation was present in the right tympanic membrane, with fœtid discharge. The hearing for the acoumeter was 16 inches. On cleansing the ear, a small superior posterior granulation was found and removed. In spite of the use of hydrogen peroxide drops, followed by antiseptic syringing, and, later, of strong rectified spirit instillations, the discharge persisted, and the granulation recurred. It was then decided to remove the remains of the drum and ossicles, together with the outer attic wall. This was done in February, 1905, when the head of the malleus and body of the incus were found to be carious, a small granulation springing from the latter close to the origin of the long (articular) process.

The case now showed a perfectly dry ear, the promontory showing as a glistening white prominence, and the head of the stapes being easily seen. Hearing was improved for the acoumeter to 40 inches, and there had been no recurrence of discharge.

Mr. Macleod Yearsley said that this case was an excellent instance of the usefulness of ossiculectomy in certain cases of chronic middle ear suppuration. It had, in all probability, saved the patient the tedium and pain of the radical mastoid operation. There were several instructive points about the case, and these he wished to take in order.

First, the presence of granulations in a suppurating ear always meant one of two things (putting aside, of course, malignant disease, which was not of very common occurrence in the ear)—either neglect or caries. In the former case, the removal of the granulation or granulations, and the establishment of proper treatment, speedily resulted in cessation of the discharge. When, however, the granulations were the result of caries, relief was less easily obtained. With regard to the part of the ear in which caries was most frequent, Mr. Yearsley said that it was probably most likely to occur in the ossicles. In reference to perforations in general, and those associated with caries in particular, he pointed out that in perforations involving the anterior or inferior segments of the membrane, ossicular caries was not usual, save occasionally in the tip of the malleolar manubrium. It was in perforations situated in Shrapnell's membrane, or in the posterior superior quadrant of the membrana tensa, that one had to look out for caries of the ossicles. The very nature of the anatomical arrangement in the attic anr the pouches behind the membrana flaccida, or membrane of Shrapnell, favoured the occurrence of caries in the head of the malleus or body of the incus.

When the perforation was one situated in the superior posterior part of the membrana tensa, the caries was generally in the articular (long) process of the incus, close to where it joined the body of that ossicle.

Of the three ossicles, caries was most common in the incus. This was due to the anatomical arrangements. Both the stapes and malleus had a blood supply independent of that obtained from the mucous membrane reflected over them. The stapes, being articulated with the fenestra ovale, was supplied by the stapedial artery and the blood supply of the inner tympanic wall. Caries of this bone was very uncommon. The malleus, having its handle ensheathed in the membrane, received blood from the vessels of that structure. Caries of its head was, however, common, on account of the anatomical arrangement of the attic.

The stapes was simply slung, as it were, between the other two ossicles. It depended for its blood supply almost entirely upon its muco-periosteum. Inflammatory swelling of the tympanum easily caused an interference with this blood supply, and, consequently, caries of the incus was common.

Mr. Yearsley next spoke of the effect of ossicular caries upon the hearing. When the amount of caries was very limited in character, its mechanical effect upon the movements of the ossicular chains, he said, was small; but when the caries was extensive, or implicated the malleo-incudal articulation, the carious bone acted as a foreign body—as a broken link in the chain, so to speak—and hearing was much interfered with. It was then that a careful ossiculectomy, which left the head of the stapes free in the tympanic cavity, gave improved hearing. Indeed, in some cases of post-suppurative deafness, in which the ossicles were bound down by adhesions, and the free movement of the stapes was consequently interfered with, removal of the ossicles gave gratifying results. In the case under observation, it would be noticed that the hearing for the acoumeter had been improved from 16 inches to 40 inches by the operation. Corresponding improvement for conversation had occurred.

But there was another point to be noted—and a very important one—in connection with ossicular caries. The focus of disease was perilously near the mastoid autrum, and mastoid disease by extension was certain to occur sooner or later. Hence ablation of the ossicles removed this dangerous proximity of a disease focus, and often prevented mastoiditis. In many cases, unfortunately, relief was sought too late to effect this prevention. The present case was one of the fortunate ones.

Finally, Mr. Yearsley said a word as to the operation of ossiculectomy itself. It consisted in the removal of the malleus and incus. The stapes remained. This removal aimed at the ablation of the disease focus (viz., the carious ossicles) and proper drainage. It must be remembered that the latter could only be ensured by the removal of the bony outer attic wall as well. If this were not done, failure was inevitable and disappointment sure.

OPERATING THEATRES.

KING'S COLLEGE HOSPITAL.

Case of Laceration of the Thorax.—Mr. Peyton Beale operated on a boy, æt. about 5, who had been brought to the hospital in the following condition—having fallen out of a window upon some iron spiked railings a few minutes previously. (1.) All the soft parts of the right arm, with the exception of part of the triceps muscle with the skin over it, were torn through, the lacerated wound extending from the insertion of the deltoid to just above the elbow. The extent of the laceration was shown by the fact that at least six inches of the media and ulnar nerves were hanging from the wound. (2) There was a lacerated wound

of the left thorax which started from the lower costal margin, extending upwards through the cartilages and the ribs to the third rib; the laceration was so great that the wound would admit of the insertion of the entire hand; the pericardium was fully exposed to view, the lung was collapsed and lying at the back of the thorax, though a portion of it was projecting into the wound; one could put one's hand into the wound and grasp the whole of the heart. The boy had several fractures of the skull; the whole of the back of the cranium was freely movable laterally and there was hardly any portion of the cranium where bony crepitus could not be elicited on pressure. A little chloroform was administered, and the house surgeon, Mr. Grell, dealt with the right arm, ligaturing the ends of the brachial artery and rapidly suturing the skin edges, leaving apertures for drainage. Mr. Beale approximated as far as was possible the torn costal cartilages with thick catgut sutures and removed several pieces of rib from the wound; he then sutured the skin, putting in a gauze drain and applying a large dressing, so as to exclude air as far as possible from the pleural cavity. He then made a free incision in the scalp, but as there was no evidence of any pieces of depressed cranium, and as there was but very little hæmorrhage from beneath the cranium, he did nothing further.

The boy was, of course, considerably collapsed, and was immediately put to bed with several hot bottles. A few hours later Mr. Beale gave him copious injections of hot salt solution into the rectum; the patient improved rapidly, and was well enough to ask for food within twenty-four hours. Thirty-six hours after admission he was alive and doing well. Mr. Beale subsequently said that if the boy recovered he should make an attempt to unite the severed nerves and muscles of the arm by removing two or three inches from the middle of the humerus and so shortening the limb.

NORTH-WEST LONDON HOSPITAL.

AMPUTATION OF THE HAND.—MR. TEMPLETON operated on a man, æt. 50, who had been admitted as an emergency for an accident to the left hand inflicted by a chaff-cutting machine. The hand was completely severed from the limb; the section, which was perfectly clean and defined, and which had passed through bone, arteries, nerves, &c., on the same plane, had a direction upwards and outwards towards the radial aspect; the osseous structures exposed consisted of varying lengths of the metacarpus, some two inches of the fifth metacarpal bone and the base of the first only being left. On admission the patient had received first aid in the casualty department from the resident medical officer, Mr. Binns, who tied several bleeding vessels. The man was admitted into the ward, and shortly afterwards seen by Mr. Templeton, who proceeded to operate in order to secure a satisfactory stump. His object in this respect was, he said, to preserve as much of the limb as possible and to retain the carpal bones. The absence of any laceration of the soft parts was, he pointed out, of very material assistance towards this end. A tourniquet had been previously applied. The forearm was shaved, thoroughly scrubbed with ether soap and biniodide spirit, and completely immersed in 1 in 1,000 perchloride of mercury lotion, whilst all the clots were cleared away. The bases of the metacarpal bones were carefully dissected, the tendons and nerves resected, and all the visible vessels secured. The margin of the skin was then cautiously trimmed. The result of these proceedings was a satisfactory flap which could be turned outwards and which could completely cover the exposed distal row of the carpus. Prior to suturing the flap in position, the head of the os magnum and the posterior margin of the trapezium were removed by bone forceps. The object of this, Mr. Templeton pointed out, was to impart a rounded rather than an angular character to the stump. The tourniquet was now taken off, and the wound entirely stitched up with silkworm gut; sterilised dressings were applied and an angular splint fixed to the arm and forearm. As the patient was rather collapsed through loss of blood before admission, ether was adminstered to produce anæsthesia. Mr. Templeton remarked that had the case been one of crushing the operation he had done would not have been possible; the clean section had inflicted very little damage to the parts adjacent to the wound, therefore he had felt justified in preserving the skin in its entirety. The very small amount of skin removed by clipping with scissors was only in order to secure complete apposition when the wound was subsequently stitched up. Had the hand been torn away, nothing short of amputation through the forearm would have secured a satisfactory healing. The tourniquet, he said, had been put on before the cleansing of the limb, as this latter process very often starts fresh hæmorrhage; the instrument was also left during the operation as a precautionary measure.

The subsequent progress of the case justified the expectation that satisfactory union would occur in the flaps. No sloughing took place, and the flaps joined by first intention. Movement of the carpus was obtainable in a fortnight, and Mr. Templeton hoped this movement would increase the usefulness of any appliance.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Sept. 23rd, 1906.

TREATMENT OF TUBERCULOUS GLANDS.

DR. CALOT, the celebrated orthopædic surgeon, has contributed an article to the *Journal des Practiciens* which is well worth reproducing. In presence of tuberculous suppuration, there are three methods of treatment—operation, abstention, puncture followed by injections.

The Value of Operations.—Without doubt, operation can claim a large number of cures where it was performed on cervical adenitis and tuberculosis of the limbs. Yet it must be remembered that the fact of large ablations does not constitute an absolute guarantee of cure, for healthy tissues may be inoculated during the operation, so that the most complete operations are followed frequently by fistulæ. Fistula is the rule in case of tuberculosis of the bones, the joints, and especially in Pott's disease, where it is never possible to make a complete operation. Many surgeons seem not to understand the harm they do in transforming coxalgia, or Pott's disease, closed, into coxalgia, or Pott's disease, open. Closed, Pott's disease has 99 chances out of 100 to get well; open, the proportion is the same, but reversed—it has 99 chances out of 100 of terminating fatally sooner or later. That is what a surgeon does who lightly opens an abscess by congestion. By the resulting fistulæ septic germs penetrate, provoking infection, fever, septic absorption, and consequent degeneration of the liver and kidneys.

and death at the end of one or more years. Such is the constant result of operations for Pott's disease. It is true the situation is different in case of superficial tuberculosis, cervical adenitis, idiopathic cold abscess, spina ventosa, osteitis of easy access, but there is always danger of infecting the healthy tissues in the course of the operation, as we have already said.

A celebrated surgeon at Paris removed a tuberculous testicle from a child æt. 13. Shortly after the operation (three months) the disease attacked the right hip joint, and two months afterwards the left hip. Hundreds of similar cases might be mentioned showing the risk of tuberculous inoculation from operation.

But where the operation is really successful, at what price is it obtained? Mutilation. Let us take a case of cervical adenitis. The operation has been in every way successful; septic infection and tuberculous inoculation have been avoided, and reunion by first intention has been obtained; but is it of small importance that (in case of a young girl) the patient bears an ugly cicatrix which to the end of her days will cause her infinite moral trouble, lessening her chances to be settled in life? Not to speak of young ladies, how many clerks and domestics are heavily handicapped by large, unsightly cicatrices which frequently hinder them from earning their bread? The following aphorism should be borne in mind in external tuberculosis: the bistoury rarely cures, frequently aggravates, and always mutilates.

Abstention.—Systematic abstention is preferable to a bloody operation. I am not alone in this opinion. A professor of the Paris faculty was wont to say that, in presence of surgical tuberculosis, it was better to fold one's arms than to take up a bistoury. I heard almost the same said at the Orthopædic Institution of Milan, where a surgeon said to me, "Formerly we opened and curetted all abscesses of coxalgia and Pott's disease; now we never touch them, and the patients do much better. If not touched, here is what happens: A large number of tuberculous abscesses become absorbed, and this is not only true of superficial abscesses, but also and particularly in those of Pott's disease, if the patient is enjoined to absolute rest and receives a good general treatment.

The remainder open spontaneously, but the risk of inoculation is infinitely less than when they are opened by the knife and curetted, while that of secondary septic infection is also less than where fistula succeeds surgical interference. That is why the fistulæ which are observed in neglected country children get well much oftener than those following the most scientific operation, and mutilation is less apparent after spontaneous rupture.

Puncture and Injections.—I hasten to say, however, that we have something better than abstention for the treatment of tuberculous abscesses. If we sin by commission in operating, we can sin by omission in leaving the abscess to open of itself. We should not only not operate nor open a tuberculous abscess, but also prevent them from opening spontaneously by puncturing them with a fine trocar, by which we obviate the risk of mutilation, septic infection, and inoculation. On the other hand, if we take advantage of the presence of the cavity of the abscess by replacing the pus by some modifying liquid which will rapidly heal the tuberculous walls, we will have satisfied the most fastidious. The cure will thus be obtained without any danger and without mutilation.

Such is the ideal treatment, and it is not a myth, but an agreeable reality.

Puncture followed by injections not only cures 99 times out of 100 without risk or deformity, but is simple and easy to execute by every medical man.

Every practitioner can obtain this successful result, provided he follows exactly the modus operandi we advise.

The instruments required are only three in number: Colin's trocar No. 4, a small aspirator, a syringe adapting to the trocar and easily sterilizable.

The operator begins by evacuating the collection by means of the aspirator adapted to the trocar, and immediately replacing the pus by an injection of one or two drachms of one or other of the following liquids:—

Olive oil	1½ ounces.
Ether	1½ ounces.
Creosote	40 drops.
Iodoform	1 drachm.
Camphorated naphtol ...	1 drachm.
Glycerine	1 ounce.

If the abscess is very ripe, the former should be employed; if only partially so, the latter. About ten injections are necessary to obtain a cure, leaving five days between each. The abscess might be aspirated every two days if necessary, and the puncture should be made in a different place each time, so as not to injure the skin, and in no instance should the needle be inserted into a point where the skin seems ready to break. Although the pus may be evacuated every two days, the injections of the modifying liquid should not be made oftener than every five or six days, and no more than ten should be given, after which compression by cotton wool and a Velpeau bandage should be made over the abscess so as to bring the walls together as exactly as possible.

GERMANY.

Berlin, Sept. 23rd, 1906.

Stasis Hyperæmia in Ophthalmology.

R. Hesse, Graz., has a paper on this subject in the *Zbl. f. Prakt. Augenheilk.* The subject had already been mentioned in an earlier number of the journal by Renner, who produced the stasis hyperæmia by means of a rubber bandage applied round the neck, but Hesse, on account of the considerable unpleasantness of such a method, employed suction.

He made use of a kind of cupping glass made to fit the part to which it was pressed, and to this was attached on indiarubber tube and at the end of this a ball.

The action took place with a different pressure of 20 to 50 mm. of mercury, with 100 mm. hæmorrhage took place from the conjunctiva. If the apparatus was applied with the eyelids closed the action was mainly on them. In five minutes they became red and swollen, in half an honr they were blue coloured and œdematous, the edges of the lids becoming slightly everted. If the eyelids could not be closed the action was quite different. The connective tissue of the lids became injected and swollen, they became sometimes quite inverted, so that the conjunctival tissue itself came under the influence of the suction. Dilatation of vessels first took place at the bulbar conjunctiva, then serous fluid collected under it, and after half an hour's action pressed forward to the corneal margin and showed the appearance of a marked chemosis. The cornea itself does not escape change. Here also the influence of increased fluid is noticeable; it appears œdematous and slightly dull on the surface. No action of the iris was noticed in the human subject, but it had been in rabbits. The anterior ciliary vessels were also affected. The deeper parts of the eye were not affected, neither was the intra-ocular pressure.

He had also used suction in pathological conditions. In pannus eczematosus he found more filling of the vessels and softening of the tissues from fluid. In keratitis parenchymatosa an exhaust action of thirty minutes caused a marked influx of blood.

In order to show the action on the ciliary vascular system, a solution of fluorescine was injected subcutaneously, and then the left eye brought under the action of an exhaust. After three-quarters of an hour there was distinct green colouring of the fluid of the chamber and of the cornea of the eye affected, whilst no trace was seen in the other eye even after an hour.

Stasishyperæmia, according to the author, may be employed in phlegmous furuncles of the lids indacryocystitis, all inflammation affections of the eyelids, the conjunctiva and cornea, and especially conjunctivitis eczematosa and trachoma.

As regarded chronic blennorrhœa of the tear sac, iritis, and cystitis, more observation is required. Lastly, the author gives the history of a case of suppurative ulcer of the cornea that had been treated in many ways, including cauterization, atropine, iodo

form subconjunctival injection of saline fluid, moist warm applications, and in spite of all steadily advanced. As soon as ever the hyperæmia was established, the pain ceased, the advancing margin of the ulcer disappeared, the hypopion was absorbed. As the treatment was omitted one day the ulcer started again, but fresh and more continued application of the exhauster or sucker brought about a complete cure.

PURULENT INFLAMMATION OF THE MOUTH CAUSED BY THE TELEPHONE.

A writer in the *Zeitsch. f. Med. Beamte*, Dr. Bunde relates a curious case of the above. A farmer who had been ill with stomatitis a fortnight and had been treated with nitrate of silver and mouth washes of chlorate of potash, came under treatment. There were swelling and softening and a blue-red colouration of all the gums, with tendency to bleeding, pasty covering over the edges of the gums, ulcers on the margin of the tongue and hard palate on the lips, and buccal mucous membrane, fœtor, and salivativa. Etiology was at first absolutely dark. The treatment consisted in alum water and peroxyde of hydrogen and painting with tinctures of rhatany and myrrh. There was improvement at first, but on a tooth being extracted everything got worse. It was several weeks before recovery took place.

Whilst this patient was under treatment, a second came, a post official, who presented similar symptoms, but not quite so bad. Now the etiology became clear. The second had had to test the telephone apparatus of the first at the time when he was ill; his mouth also was close to the mouthpiece, as the apparatus was working badly.

The post office was communicated with, and the authorities promised to make arrangement for the prevention of such occurrences for the future, *i.e.*, they would issue instructions that in speaking the mouth should never be brought into contact with the receiver of the instruments. The report does not state when contact between the receiver and the lips or even moustache of the speaker is considered necessary, or rather was considered necessary previous to his warning communication.

AUSTRIA.

Vienna, Sept. 23rd, 1906.

SERUM IN CROUPOUS PNEUMONIA.

TAUBER reviewed his treatment with Romer's pneumococci serum in cases of croupous pneumonia, in the "Allgemine Krankenhause," and expresses himself satisfied with the results. The serum is prepared by Merck of Darmstadt, from horse, cattle and sheep which are inoculated directly from the human subject. The serum is described as bactericidal and polyvalent. The dose commences with 10 c.c., increasing to 30 c.c. injected into the muscles. No local or serum exanthema are to be observed.

Of the 46 cases treated last year with the serum, nine were very severe. diplococci pneumonia, and five croupous pneumonia, with different excitants. The serum had very little influence over the latter cases. This can also be said of one case of caseous pneumonia with advanced tuberculosis, as well as a confluent lobular diplococcus pneumonic case, æt. 61, suffering from chronic tuberculosis. Of the first nine cases, seven of them had the temperature reduced to normal within ten to fifteen hours after the first injection. In the case of a drinker with right lung inflammation, 30 c.c. were injected in the evening; in the morning, or thirteen hours after the injection, the temperature was down, but the pulse steady at the same as the night before. By midday, the temperature rose again to 38.2 C., but in the evening it again fell and remained low ever after. In every case the subjective symptoms were greatly improved, the patients expressing themselves greatly relieved. Tubercular cases do not appear to be influenced beyond the subjective symptoms.

HYDROCEPHALUS.

Fuchs next showed an athlete, æt. 25, who had all the symptoms of micromelia. He appeared as a caricature of normal body and very short extremities. The Röntgen Rays showed a very low development of the epiphyses with distortion and contraction of the diaphyses of the long bones. The thyroid and genitals were normal, but the intelligence low.

TORSION OF THE HEAD.

Fischl showed a very interesting case for the anatomist of a young man who is engaged in variety work on the stage. From long practice he was able to turn his head 180° on the body, or, in other words, he could turn his face directly backwards. As might be expected the muscles in their natural position could not place the head in this diametrically opposed position, but with the assistance of the hands and the lax condition of the ligaments around the atlanto-epistropheal joint he could smartly place his head in a posterior attitude. This distorted position could not long be sustained, owing to the danger of suffocation from the stretching and distortion of the trachea. Notwithstanding this abnormal twisting of the head on the body, the lateral movements were normal. Fischl pointed out that the anatomy of atlanta joint required no abnormal bony change to produce the movement, as the freedom of the ligaments was all that was required, which had been unduly stretched by long and continuous straining.

CHILDREN'S HOSPITAL.

A new annex to the "Franz Joseph Spital" has just been opened by the Emperor himself, with great *eclat* and demonstration. This portion, "H" and "I" divisions, are built with the latest scientific improvements, and embellished in the most artistic fashion. "H" is devoted to tubercular and scrofulous children, while "I" is for general ailments, with "boxes" for mother and child or children, as some of them are fitted for three children with mother. "I" has also a fine "Couveuse," or incubator, so that the embryo can now be incubated without the assistance of the female!

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

BELFAST.

THE PUBLIC HEALTH QUESTION.—The health of the city, and the steps which ought to be taken to improve it, continue to be the general topic of conversation in Belfast, and matters seem to be approaching a crisis. As was reported in this column last week, the Corporation decided, in spite of all opposition, to offer only £600 per annum for a Medical Officer of Health, though they give their Coroner £550 and allow him to take private practice also! It is recognised on all sides that the object in view is to prevent any really good outsider from applying, and to appoint a local general practitioner, lately a member of the Corporation. There is a strong and growing feeling that the intense keenness of the City Fathers to perpetrate such a very gross job in the face of strong opposition is by no means entirely due to their friendly feeling to their late colleague, but is at least partly due to fear of what a good independent medical man might do in the way of throwing light on the dark places of the city, slums and jerry-built houses, in which the members of the Corporation are largely interested. An interesting proposal has been made, and we earnestly hope it may be carried out, and that is to make out a list of all members of the Corporation who are interested in house property or building (as many of them are known to be), and publish it with a parallel list of those who have steadily voted against getting a thoroughly qualified Medical Officer of Health. A medical member of the Corporation has assured your correspondent that the result would be very striking.

Meantime, the advertisements for the post have been published, but they were sent to certain medical journals timed to appear on September 22nd, the day on which applications were to be sent in! When attention was called to this in the Press, it was explained

that notices of the vacancy had been sent direct to the Public Health Officers of many English and Scotch towns, but only a week before applications had to be sent in. The whole business is an exceedingly disgraceful one, and the Citizens' Association has done well in calling a public meeting for Thursday, the 27th, to consider what steps can be taken to mend matters. One suggestion is that a Royal Commission be asked for, to inquire into the health of the city, and the reasons for its deplorable state. No doubt strenuous efforts will be made by the property owners to prevent such a disaster as this would be to them.

LETTERS TO THE EDITOR.

SANITARY ADMINISTRATION.

To the Editor of the Medical Press and Circular.

Sir,—In the *Times* of Saturday last appeared a leading article based upon the Local Government Board's Medical Report for 1904-5. The article, by an able writer, is one of a kind familiar to readers of the leading journal. These articles really constitute a reiterated indictment of local governing bodies. They reiterate in slightly varied terms the statement that if those bodies could be made to carry out the laws with the administration of which they are entrusted, the mortality throughout the country could be reduced by one-half. The *Times* asks what is the use of establishing societies for the promotion of bodily vigour whilst the gross fundamental abuses it describes are allowed to continue—abuses which form the prime cause of physical deterioration among that section of the people from whom the best stock should be produced. Sanitary administration is at its worst in the smaller "urban" districts inhabited by what are really rural populations. When it comes to the suggestion of remedies, the *Times* does not lead us much further. It is useless to talk of giving fixity of tenure to Medical Officers of Health whilst many authorities either refuse to employ such an officer or else pay and engage him to give a totally inadequate portion of his time to perform his duties. Not much more practical is it to suggest that increased powers of coercion over authorities should be conferred upon the Local Government Board. This would need new legislation, and would be an interference with democratic methods and institutions. The real hope of reform lies in the improvement in the quality of the authorities. This can be brought about only by the rousing of public spirit and local patriotism. So long as the better class stand aloof, and allow themselves to be represented by ignorant and selfish men, so long will the existing evils continue. These evils are detrimental not only to the parish in which they prevail, but they also inflict deadly injury upon the nation, which is merely the sum of the units into which, for convenience of government, it is divided.

I am, Sir, yours truly,

M. O. H.

DANGER OF TEA DRINKING.

To the Editor of The Medical Press and Circular.

Sir,—In my rather wide experience I have continually met patients who have been debarred tea. As a very general rule, I restore the use of the tea to the great comfort of the patient.

"Affirmative Instances"—*i.e.*, concluding from a "few times hitting," and ignoring the "many times missing"—Bacon tells us, are "the roots of all superstition." Remembering this caution in method, I may yet say that I have drunk tea after dinner for thirty-five years, with great comfort to myself. My father lived to 87 years, and always had his cup of tea after dinner for 70 years. He was a total abstainer from alcohol.

Look at the labourer digging up the gaspipes or sewers of our streets. He eats his cold bit of meat or cheese and bread, but enjoys the drink of hot tea after his frugal meal.

See the Australian shepherd or bushman, with his rather tough damper; he enjoys his pannikin of hot tea after his meal. The Canadian lumbermen, the Mongolians, the Tartars, the Russians, the Chinese, all enjoy their tea. I never knew an Australian bushman or Canadian, or John Chinaman blame the use of tea.

I fear that if I gave up my after-dinner tea, I should long for claret or cold spirit and water!

There are pernicious fashions in medical practice; let us guide our patients into the rational use of tea, &c., and not debar their right use. One highly fashionable West-end physician debars "genteel" lady patients the use of "raw" fruit—an astounding folly in my opinion! I have eaten fruit freely all my life, with natives of Australia, India, South Africa, West Indies, &c., and I have known only good from such custom. One cannot sufficiently express one's repugnance at the fashionable physician hindering the use of fruits, potatoes, &c., to *parvenue* ladies, who are told that they are "too delicate to digest raw fruits"! The contrast and wisdom are seen in the West Indies, where the negro rejoices in munching a long stem of raw sugar-cane; and in the East Indies, where the wise and highly civilized native rejoices in the use of the lime, or tamarind, or mango, &c.

Forty and more years ago, when I was in charge of natives of India, I introduced the use of tea, and to the great satisfaction of the people. I formed the opinion then that some such "aromatic" molecule as tea, coffee, &c., was greatly needed in their too sparse diet.

Tea may, if taken soon after a meal, check the flow of gastric juice, but so will a glass of grog; none the less, the tea and the grog will light up and set free potential into kinetic "energies" and motions, which will counteract the little temporary check in gastric secretion. What we hypothetically call "the vital" is set going by the stimulant; a bare present chemistry is no measure of the (hypothetical) "vital."

I am, Sir, yours truly,

Abdool Raheem, M.D.

September 19th, 1906.

MOTOR-CARS AND DUST.

To the Editor of the Medical Press and Circular.

Sir,—My absence in Canada, attending what proved to be a very successful meeting of the British Medical Association, prevented my noticing at an earlier date Dr. Wilson's answer (1) to my recent letter on Motor-Cars and Dust (2). This reference to Canada suggests the passing remark that at Toronto quite a common and agreeable sight was afforded by young ladies—girls, in fact—driving their own motors.

I think I am justified in expressing the opinion that Dr. Wilson's comments scarcely succeed in meeting my main objection. I insist upon the fact—and I am glad to find that you can partly agree with me—that the motor-car, and especially the car provided with pneumatic tyres, cannot create dust in any appreciable quantity. That it distributes dust—largely produced, let us remember, by the horse—is quite another question. I can even perfectly understand that "within the last year or two special legislation has been found necessary to control the origin of this dust, and that people living in main roads most traversed by motor-cars are giving up their houses and removing to side streets not patronised by the modern Jehu." This is no more than what should be expected.

But such facts are not a sufficient reason for condemning the motor-car, unless, indeed, we are prepared to denounce the railway and the steamboat. The motor is a factor of considerable importance—and this importance can only grow—in our modern social development. Every progressive community will encourage its use, for every such community will understand that material and even intellectual progress are closely connected with improved facilities of communication.

We perhaps do not grasp all the conditions of the problem. We may not always remember, for instance, that for one person who travelled a century ago there

(1) Med. Press and Circ., Aug. 8th. (2) Aug. 1st.

are ten or a hundred travelling to-day. Who dreams of giving the avenues of a modern city the dimensions of mediæval streets and alleys? It is not reasonable to expect our present thoroughfares to meet all the requirements of incessantly increasing traffic. Why not create special highways for the motor?

This is what must soon be contemplated as a necessity for the Riviera, where the Villefranche road is being already widened. For the evil pointed out by Dr. Wilson could scarcely be exaggerated. The prevalence of dust is indeed a cause of general complaint both amongst our residents and visitors. But "Nice, with the other beautiful health resorts," and the hotelkeepers in particular, will endure a good deal of "ruining" so long as the motorist is not unjustly discouraged.

There is one last point in favour of the motor-car that I would not like to omit. Its rapid adoption as a substitute for the omnibus drawn by horses in the streets of London will, it is to be hoped, discourage the development of the tramway. Anything more unpleasant, I am sure most of your readers will allow, than the incessant din of the unsightly American road-car could scarcely be imagined. And this is not the only or even the chief objection to be urged against it.

I am, Sir, yours truly,
A. W. GILCHRIST, M.D.

Nice, September 23rd, 1906.

DISTRIBUTION OF HONOURS.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—I trust that you will grant me the hospitality of your columns to ventilate a personal grievance under which I have been suffering for many years. You, sir, and your readers are doubtless aware of the scanty way in which decorations for distinguished services are awarded by the Indian Government to medical officers. I think my own case illustrates this hardship so forcibly that I venture to send you a *resume* of my services, and to ask if you think I have been fairly treated. In forming a judgment on the merits of the case, I would beg of you to remember that it has been my lot to see a number of medical officers with far less experience and war-service than I, presented with honours and decorations of various kinds, and while I have nothing to say against their abilities and deserts, I must say that I think my name should have been included among them. The majority of military officers who served during the memorable Mutiny at the same time that I did have been decorated with high honours.

As to my own case, I may say that it is fifty-three years since I first sailed for India, and that soon after landing I saw active service in the first Meranzie Expedition. When the Mutiny broke out I was attached to the Punjab Cavalry and I acted as Brigade Major under Sir Crawford Chamberlain during the critical procedure of disarming the native troops at Mooltan; in fact, it was I who carried the message to the cavalry, to open order and expose the guns, the manœuvre on which the whole success of the undertaking depended. In the taking of Bullee, I served under Colonel Sir W.T. Hughes, and was able to lend him much assistance during that dangerous operation, and again the following day, when he was surrounded by the mutineers I managed to run the gauntlet with a party of picked men and bring up reinforcements. For this act I was specially thanked by the Commander-in-Chief. During the rest of the Mutiny I was constantly on duty, both medical and military, and was never laid up for a day. In 1860, I was in medical charge of the Guides during the Wuzuri Expedition, and when Sir Harry Lumsden's camp was surprised and rushed by the enemy during the night, I was able to rally some 200 men who had broken and bring them to relieve the others who were overwhelmed and nearly cut up by the Wuzeeries. I had an almost miraculous escape from being killed myself, and my name was specially mentioned by Sir Harry Lumsden for the help I afforded him. I held many responsible medical posts in India. I was in joint charge of Simla during the cholera outbreak of 1866-67, when I received the thanks of the Lieutenant-Governor of the Punjab; I was sanitary officer to the great Durbar of '76, when the Queen was proclaimed Empress of India; and I was in charge of the Dinapore Dispensary and Dera Ismali Khan Dispensary, from both of which places I received special acknowledgements for my success in operating for stones and cataract, and in stamping out the cholera epidemic of '73-'74. In fact, so well known was I to the frontier tribes that when I was at the latter place I was invited to go to Cabul to practise. I also invented the "Tuson" helmet for the protection of troops in tropical countries. I must not take up more of your space with the details of my career, but I think, sir, you will agree that many less arduous and important ones have received substantial recognition from the Indian Government.

I am, Sir, yours truly,
JOHN E. TUSON, M.D., F.R.C.S.

Eastbourne, Sept. 7th, 1906.

FOREIGN *VERSUS* ENGLISH SPAS.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—I was somewhat amused at your "light and breezy" reference to foreign and English Spas last week, under the heading of "The Marienbad Cure," and the motives and habits of certain of the British public who yearly frequent the Continental health resorts, instead of those at home. It is, of course, ridiculous, as you remark, to imagine that the waters possessing similar medicinal qualities in this country would be less effective when administered here than abroad; but habit and fashion govern most things in this world where money is concerned, and I fear we must admit complicity to a certain extent in this diversion. We send our patients to the Spas of France, Germany, or Austria, but do we ever hear that our *confrères* in those countries send their patients to English Spas? During my annual holiday this summer I happened to be in the Peak district of Derbyshire. I had read of its natural beauties, but knew nothing personally of them; judge my surprise when passing through the Derwent Valley to find at Matlock Bath a large hotel fully equipped with every bath appliance one could meet with at Marienbad, Nauheim, or Mont Dore, with its mud-baths and its natural springs, all under the control and direction of an English physician (who appears to have studied the Continental systems), amid natural scenery unapproached by anything I have seen abroad. Yet I must perforce admit that I was unaware up to a few weeks since that such a Spa existed. I, of course, knew a little of Matlock, the "Metropolis of Hydropathy," where there is no Spa or natural spring; but of Matlock Bath and its up-to-date bathing establishment attached to the Royal Hotel, I was ignorant, and it occurred to me what a delightful spot this would be for the invalid as a winter resort, surrounded as it is with the High Tor and other peaks clad with conifers, larches, and evergreens, and protected from north and east winds. Yet our patients often undergo the discomforts and expenses of long journeys abroad, which could easily be avoided did we take the trouble to visit our Spas at home, and find out for ourselves their suitability in certain cases which we now send elsewhere.

I am, Sir, yours truly,
M.A., M.B., CANTAB.

London, Sept. 19th, 1906.

DURING the year 1905 two "professional" deaths occurred amongst old St. Mary's Hospital men, namely, that of Mr. Harold Hand, from *post-mortem* septicæmia at the Norfolk and Lynn Hospital, and that of a brilliant Army officer, Lieutenant A. F. Tulloch, who died of sleeping sickness contracted on an expedition in East Africa.

OBITUARY.

ANDREW M. L. RATTRAY, M.D.

On September 18th the death occurred of Dr. Andrew Rattray, Portobello's oldest medical practitioner. He was educated at Edinburgh University, where he took his M.D. degree in 1862. Dr. Rattray served on the Portobello School Board till its functions were taken up by Edinburgh School Board. He took much interest in the movement to suppress cigarette smoking by the young. He is survived by his widow and three sons and one daughter, two sons being medical men and the third an Army officer.

THOMAS LUCAS, M.R.C.S., L.S.A.

Mr. Thomas Lucas, of Cambridge, died suddenly on September 20th. Educated at Middlesex Hospital, he took the diplomas of M.R.C.S. and L.S.A. in 1863. He went into practice at Cambridge, where he soon achieved great popularity. He had a large clientèle among undergraduates, to whom he acted as mentor in other matters besides medicine. He took great interest in the University hunt and the Polo Club, and was for a number of years judge at the University steeplechases at Cottenham.

JOHN GILMOUR KERR, M.B., C.M.

Great regret is felt at Cumnock at the death of Dr. J. G. Kerr, which took place on September 17th, after a long illness. He was only in the fortieth year of his age. A native of the parish of Neilston, he took the medical classes at the University of Glasgow, and soon became a medical practitioner when but little more than twenty-one, and seventeen years ago he went to Cumnock as assistant to the late Dr. Lawrance. On the death of Dr. Lawrance some twelve years ago, he succeeded to the whole of the large practice, being doctor for the large ironworks of Messrs. William Baird and Co. at Lugar, and also for the parochial board of the parish. Dr. Kerr was a Justice of the Peace for the county, and both as a doctor and a gentleman he was highly trusted and beloved. He leaves a widow and one daughter of tender years.

DAVID HENRY GOODSALL, F.R.C.S.

Mr. David Henry Goodsall died suddenly from heart failure at his residence, 17, Devonshire Place, W., on September 14th. He received his professional education at St. Bartholomew's Hospital. In 1868 he became a member of the Royal College of Surgeons, England. After holding a resident appointment at his own hospital, he became house surgeon to St. Mark's Hospital. In 1872 he was admitted a Fellow of the Royal College of Surgeons. After holding the post of assistant surgeon to St. Mark's Hospital, he became surgeon and eventually senior surgeon, and retired from the hospital on attaining the age limit. At the time of his death he was also senior surgeon to the Metropolitan Hospital, and surgeon to St. Saviour's Hospital. He was joint author (with Mr. W. E. Miles) of "Diseases of the Anus and Rectum," and he contributed papers on the same subject to various journals. He was an able surgeon, and he obtained excellent results in the special branch to which he had devoted his energies. He was a good man of business, and held for many years, among other posts, the office of director of the Western Telegraph Company. By the Medical Society of London his loss will be severely felt, as he was for 19 years chairman of the house and finance committee and honorary treasurer since 1896.

PROF. ISIDOR VON NEUMANN, OF VIENNA.

Many a practitioner and student in this country will be grieved to learn that Prof. Neumann passed away last week rather suddenly. He was recognised as the leading authority on syphilis, to which he devoted a great part of his life. Born in Moravia, 1832, he had thus reached his 74th year at death. He took the degree of Doctor of Medicine in Vienna, 1858, and three years later was appointed assistant to the Chair of Dermatology and Syphilis, which he subsequently succeeded to in 1887 on the death of Prof. Siegmund, and which office he held till 1903, when the rules of the University demanded his retirement on the age limit. This enforced retreat from office gave him much pain, and not a little to his friends, who considered him fit and capable for the duty. Kaposi was his great rival, and, being a more ready speaker and better elocutionist, carried his audience with him, while Neumann forced his logic with humour and wit, at which he was an adept. Both have now gone, and left the Vienna school much the poorer. Neumann was an extensive writer (several of his lectures appeared in our own columns), and many of his works have been translated into other languages besides English. He had always a weakness for the latter, which fact gave the English student a higher estimate in his favour. He is reputed to be the first who classified Pemphigus Vegetans, but his name will be long remembered by his text-book on syphilis.

DR. HENRY TWEEDY, OF DUBLIN.

We regret to have to record the death, at the very advanced age of 96, of Dr. Henry Tweedy, of Rutland Square, Dublin, who was, we believe, the "Father" of the medical profession in Ireland. Dr. Tweedy obtained the licence of the Royal College of Physicians of Ireland in the year 1836, and the membership of the Royal College of Surgeons of England in the same year. In 1838 he became a Doctor of Medicine of the University of Glasgow. In his student days he was a pupil of the late Mr. Cusack at Dr. Stevens' Hospital in Dublin. For some years he acted as private medical adviser to the Duke of Manchester, and subsequently practised in Dublin. Dr. Tweedy was well known for his deep interest in the welfare of the poor, and his devotion to charitable and religious objects. His interest in the practical side of his profession was also great, and from time to time he contributed articles to the columns of this journal. Many of his relatives are well-known members of the medical profession, notably his son, Dr. H. C. Tweedy, for many years one of the physicians to Stevens' Hospital; his nephew, Dr. Hastings Tweedy, the present Master of the Rotunda Hospital; and his son-in-law, Sir William Smyly, one of the former Masters of the same institution. Up to a short time before his death the late Dr. Tweedy was conspicuous for his wonderful mental and physical activity, and, indeed, it was partly due to the latter that at the end his death occurred suddenly, as, a few days prior to it, he had a severe fall, which resulted in an intra-capsular fracture of the femur.

SPECIAL ARTICLES.

THE HEALTH OF THE ARMY.

The Report of the Army Medical Department for 1904 has recently appeared, and it contains much information of value to those interested in medical statistics. Like most Government publications its arrangement is difficult for purposes of reference, and it is no easy matter to pick out from a mass of dry-as-dust details the facts and figures of real importance. As we presume even yellow books are meant to be read, or at any rate used for reference, we have never been able to see why such volumes are not furnished with indexes.

We find that the sick admission rate and death-rate for the year represent proportions respectively of 653.1 and 6.19 per 1,000 of strength, as compared with 758.1 and 7.13 in the previous year. The principal causes of admission during the year were venereal affections, diseases of the digestive system, injuries, malarial fevers, diseases of the skin and diseases of the respiratory system. The chief causes of death were enteric fever (433), injuries (188), diseases of the digestive system (187), diseases of the respiratory system, ex-

cluding tubercle of the lung (147), and diseases of the circulatory system (121). The invaliding records show that diseases of the circulatory system (862), diseases of the digestive system (749), diseases of the nervous system (635), diseases of organs of special sense (553), and tuberculous diseases (476) head the list in the case of men finally discharged as unfit for further service. Malarial fevers, debility, enteric fever, Malta fever, and dysentery caused a great deal of invaliding from abroad, but in most of the cases, change of climate greatly benefited the health of the men and good recoveries occurred.

As regards the prevalence of particular diseases in the Army, we learn that the admission and death-rates from tuberculosis have shown a steady diminution during the past twenty years, whereas the invaliding rate has remained practically stationary. Syphilis shows some diminution in all parts of the Kingdom except Scotland, where it appears to be on the increase.

The principal operations necessitated by the various cases admitted to military hospitals in the United Kingdom during the year were more numerous than in the preceding year. Chloroform was the anæsthetic used in the majority of cases; ether was also used (222 instances) and gas (112 instances); while gas and ether, ether and chloroform, nitrous oxide and ether, cocaine, ethyl chloroform, chloroform and alcohol, eucaine, and ethyl chloride were used in a few instances.

We are glad to notice that the work of the department in dental surgery is considerable, some 50,000 men having come under treatment.

The references to research or original work by officers of the department are not considerable, though a useful note is furnished with reference to the investigation of Malta fever by Major Horrocks and his colleagues.

The figures regarding recruiting may possibly throw some light on the state of health of the classes from whom recruits mostly come. Of 70,346 recruits inspected, it appears that 24,782, or 352.29 per 1,000, were rejected after the first inspection or within three months of enlistment. The largest number of rejections on inspection was caused by defective development. Among other causes of rejection, loss or decay of many teeth was the most frequent, defective vision coming next, and then, in order, defects of the lower limbs, disease of the heart, flat feet, varicocele, varix, and hernia. It is remarked that recruits between eighteen and nineteen years of age give the greatest number of those passed fit for the service, the number gradually diminishing at each age from that upwards.

ABSTRACT OF REPORT OF LOCAL GOVERNMENT BOARD ON SMALL-POX IN DEWSBURY

THE last report of the medical officer of the Local Government Board, just issued, deals with an inquiry held towards the end of 1904 into the prevalence of small-pox in Dewsbury and district, in the West Riding of Yorkshire.

"For a long time," says Dr. S. W. Wheaton in his report, "Dewsbury town has been the centre of a movement in opposition to vaccination, and the surrounding urban districts have participated to a greater or less extent in this opposition. The Guardians of the Dewsbury Union have not only persistently neglected carrying out their duties under the Vaccination Acts, but have even taken up an attitude of opposition to the laws to which they were intended to give effect, with the result of very greatly discouraging the practice of vaccination."

"Although an interval of several weeks had occurred at the beginning of the year during which the hospital contained no patients, the Town Council had taken no steps to cleanse it or to put it in repair so that it would be ready in case of a fresh outbreak of small-pox. It was surrounded on three sides by an open rail fence, but there was no fence on that side facing the occupied portion of the cemetery; hence a particular patient found no difficulty in escaping at night time from the hospital, with the result that he was discovered at his home having supper with his relatives. The hospital consisted of a collection of small galvanised iron buildings, and had a very dilapidated and forbidding appearance; nearly all the windows were broken, the apertures having been stuffed with paper or rags. The interiors of the wards were very dirty."

On a second visit Dr. Wheaton found that "the Guardians had taken no action for the opening of a vaccination station, or for granting any facilities to the population for the obtaining of gratuitous vaccination or re-vaccination; or for informing people of the advantage of securing the protection afforded by vaccination and re-vaccination; or for publishing the means whereby they could obtain this protection for themselves and their children."

Of the adjoining Ravensthorpe Urban District, Dr. Wheaton writes:—

"The Ravensthorpe small-pox was attributed to Dewsbury, with which the district is continuous, and more particularly to the influence of the Dewsbury small-pox hospital, which was situate close to the boundary of Ravensthorpe. The district is one in which there had been for a long time strong opposition to vaccination, and although large numbers of persons were now seeking the protection of vaccination and re-vaccination, these were not necessarily persons who had been most directly exposed to infection. In many instances parents refused to have their children vaccinated, although small-pox was actually present in their dwelling, and thus many secondary cases occurred. It was almost hopeless to anticipate obtaining a site suitable for a small-pox hospital in such a thickly populated district. The administration of the Council for the prevention of small-pox was found very inefficient; they had no disinfecting apparatus, consequently the clothing of contacts and the clothing and bedding of sufferers by small-pox could not be properly disinfected, and owing to the retention of small-pox cases in their homes infected dwellings could not be disinfected; in most instances members of the invaded family who were going to work sought lodgings elsewhere, other members who were children or who had no occupation remaining at home. The Council were providing the persons retained at their homes with food and firing, and were employing men to bring food to them and to keep watch on them, in order to prevent them leaving their homes and mixing with healthy people at shops and other places of public resort; also these watchers were to stay with patients who were delirious or otherwise troublesome."

Of a second visit a month later, Dr. Wheaton reported:—"In spite of my advice on a former occasion the Council had not insisted upon the vaccination and re-vaccination of persons employed by them in connection with small-pox, and as a result three of them had already contracted the disease. I visited a number of the infected houses and found that nurses had not been provided, and in many instances persons who were only just recovering from small-pox and were quite unfit to be out of their beds were attending on relatives who were in the acute stage of the disease.

"In many instances healthy people had to sleep with persons suffering from small-pox, and children were being recklessly exposed to the infection, their parents in many instances refusing to allow them to receive the protection afforded by vaccination. In one small bedroom in a particular dwelling I found three adults suffering from small-pox; one single woman, aged 25, in one bed, and two single men in another; another healthy woman slept at night in the same bed with the female above referred to as suffering from small-pox. Parents still refused to have their children vaccinated. The Ravensthorpe people appeared, indeed, to be quite apathetic as regards small-pox and to have become accustomed to its presence, regarding it as a calamity which it was hopeless to fight against."

LITERARY NOTES.

A NEW edition of Dr. Cheadle's work on "Artificial Feeding and Food Disorders of Infants" has just been issued by Messrs. Smith, Elder and Company, revised and edited by Dr. J. F. Poynton, of University College, London.

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MESSRS. BAILLIERE, TINDALL AND COMPANY have published this week new editions of Professor Moynihan's "Retro-peritoneal Hernia;" of Professor J. A. Lindsay's "Lectures on Diseases of the Lungs;" and of Dr. J. A. Shaw-Mackenzie's "Nature and Treatment of Cancer."

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A NEW edition of "The Extra Pharmacopœia" has just made its appearance under the editorship of Drs. Harrison Martindale and W. Wynn-Westcott. This edition contains references to the pharmacopœias of Austria, Holland and Belgium of 1906 and to those of the United States and Spain of 1905. Mr. H. K. Lewis is the publisher.

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DR. RENTOUL, of Liverpool, has a work in the press on "Race Culture, or Race Suicide?" The author's views are well-known to our readers, and the new work is "a plea for the unborn," and the giving of more attention to the begetting of a healthy race. It is written for medical and non-medical thinkers; and the causes of degeneracy are discussed in twenty-one chapters, while suggestions are made for the prevention of an increase of degeneracy.

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MESSRS. JOHN WRIGHT AND COMPANY, Bristol, will shortly issue a complete set of large midwifery diagrams, designed for the use of lecturers to midwives and elementary students, by Dr. Victor Bonney. The set will comprise 160 figures upon 24 large sheets, 2 ft. 2 ins. by 3 ft. 4 ins. The figures are intended to constitute a complete pictorial course in the subject.

REVIEWS OF BOOKS.

MANUAL OF ANATOMY (*a*).

THIS treatise of anatomy will be completed in two volumes, the first of which is now before us.

Vol. I. contains Osteology, and the descriptive anatomy of the upper and lower extremities. The first 259 pages are devoted to Osteology. Pages 1 to 10 explain descriptive terms and discuss the structure, microscopic appearance, ossification, &c., of the bones in general. A clear and minute description of the individual bones and groups of bones follows. The drawings of the bones have the origins and insertions of muscles delineated in different colours, and all the prominent features are plainly labelled, thus further assisting the reader who is working up the already lucid text. An account of the structure, varieties, and ossification of each bone, with further figures, completes its description.

Pages 260 to 263 contain general considerations under the heading Arthrology. The special joints are not described here, but are dealt with in separate sections in the order in which they are met with in the course of an ordinary dissection. The description of each joint is complete in itself. The muscular relations, artery and nerve supply, movements and muscles concerned in them, are given in different paragraphs.

Pages 264 to 398 are allotted to the anatomy of the upper limb. The part for descriptive and dissecting purposes is divided into regions—as the back, pectoral region, &c. In each section is described the structures as they are encountered during dissection, commencing with the surface landmarks. The account of each structure is as comprehensive as possible, although it may not be confined to the region under discussion. In dealing with a muscle, for instance, a paragraph is given to its origin, insertion, nerve supply, and action. Full instructions for dissection occupy the last twelve pages of the upper limb. This guide is printed in small type, is of compact form, and besides giving the skin incisions and the method and order of procedure, enumerates in detail each structure which should be exposed. In the remainder of Vol. I. the lower limb is similarly treated.

The object the author, Professor Buchanan, has set before himself in writing this manual, and which he has achieved so successfully, is to combine a text-book of systematic and practical anatomy; and also to provide the student with a complete treatise on the subject, in which their examinational requirements have been constantly kept in view. The book is of convenient size, and the illustrations, which have for the most part been specially prepared for it, are very practical. The printing is excellent and judiciously interspersed with thick type. In conclusion, the whole arrangement of the work is admirably calculated to ensure its popularity as a text-book of anatomy.

(*a*) "Manual of Anatomy, Systematic and Practical, including Embryology." By A. M. Buchanan, M.A., M.D., C.M., F.F.P.S.Glas., Professor of Anatomy in Anderson's College, Glasgow; Examiner in Anatomy for the Triple Qualification of the Scottish Licensing Bodies; &c., &c. Vol. I. Osteology, Upper Limb, Lower Limb. Pp. xvi. and 596. Illustrations 266, mostly coloured. Demy 8vo, 12s. 6d. net. London: Bailliere, Tindall and Cox. 1906.

MONRO'S MANUAL OF MEDICINE. (*a*)

AMONG recent students' Manuals of Medicine, Professor Munro's work has quickly made for itself a popular place, as is sufficiently evidenced by the call for a second edition so soon after its first appearance. The volume is a compact, concise, business-like and yet scientific presentation of the principles and practice of medicine, freed from redundances and devoid of superfluities, yet supplying the students in crisp and readily grasped teaching, essentials to face the terrors of the examination room with confidence, and to meet the trials and responsibilities of practice in after years. In the present edition the whole work has been carefully revised and brought into line with the most recent views, much new additional matter appearing, particularly in such subjects as tropical splenomegaly, trypanosomiasis, and peroplasmosis. The sections are evidently intended to meet the requirements of the average student and for such the manual is likely to become a great favourite. The lengthy section on the nervous system is particularly good, one of the most scholarly which has come under our notice, and of itself sufficient to attract attention. A more liberal use of illustrations would certainly be an advantage, and in some parts would diminish the need for verbal descriptions, but as illustrations are not usually found in text-books on "medicine," the forty-one here given may be the beginning of favours to come. The volume is a valuable addition to the now popular "University Series" of Manuals for Students.

DU LABORATOIRE A L'USINE. (*b*)

THIS is a very good example of the "popular science" handbook, written as it is in literary French as untechnical as circumstances permit. Although the subject has no strictly medical bearing, it is interesting in that it traces the evolution of various departments of scientific research more or less closely allied to medical diagnosis and treatment, as, for instance, electro-chemistry, the Rontgen and Becquerel rays, and so on. One cannot but envy the lucidity of style in virtue of which the most recondite hypotheses and the most complicated reactions are brought within the reach of the general reader. After the perusal of such a volume even the non-scientific reader possesses a

(*a*) "Manual of Medicine." By Thomas Kirkpatrick Munro, M.A., M.D., Physician to the Glasgow Royal Infirmary, and Professor of Medicine in St. Mungo's College. Pp. XX. 1,023, with 41 plain and coloured illustrations. Demy 8vo. Second Edition. London: Bailliere, Tindall and Cox. 1906. Price 15s. net.

(*b*) "Du Laboratoire a l'Usine. By L. Houllevigue. (Paris: Armand Colin). Price 3fr. 50c.

good general idea of the immense progress that has been effected in the domain of industrial science during the last quarter—or shall we say half-century. He is enabled to follow step by step the laborious series of experiments which enabled Aver to perfect his wonderful incandescent gas light and the hardly less brilliant advances in the matter of electric lighting. That there remains ample margin for further discovery is evident when we are told that the ordinary candle only yields 14. the incandescent gas lamp 50, and the arc electric light 250, hundred thousandths of their theoretical value as illuminants. After the marvels of the heat rays come the marvels of cold, with which Professor Dewar's epoch-making demonstrations have familiarised the newspaper readers, though but few among them, we apprehend, could give even a vague idea of the mechanism by which these extraordinarily low temperatures are brought about. Unquestionably, however, the acme of interest is reached when we come to consider the properties of the various "rays," the disconcerting wasteless energy of radium, and are introduced to the "ions" in restless movement that constitute the various forms of matter. One's faith in the atomic theory is rudely shaken, and reason totters on its balance as we are confronted with the possibility of all matters being merely different conjugations of ethereal ions. The work comprises chapters on the evolution of machinery and the transformation of energy, the development of electrical energy by water power as well as on the subjects just referred to.

CLINICAL PATHOLOGY. (a)

THIS bulky, well printed and attractive volume is a translation of the third German edition of Professor Korchl's "Pathologische Physiologie." The translator has, however, employed the title given to the first German edition, which, although more familiar to English and American readers, does not perhaps quite so well emphasise the point of view and character of the work of the author as is clearly indicated in Professor Osler's introduction:—"Just as physiology deals with functions of the normal body, so pathological physiology deals with the functions when organs are placed under pathological conditions; and this is the subject of our discourse." In most medical schools general pathology and special morbid anatomy receive much attention, but morbid physiology is undoubtedly much neglected. This work, therefore, in its English dress, should be welcomed both by teachers and senior students. It is a work which should do much to minimise and discourage that unfortunate and altogether unscientific antagonism which, among many, undoubtedly exists between theoretical medicine as expounded in accordance with modern biological principles and the elaborate practice of the art and technique of present day clinical medicine. The avowed purpose of this book is to contribute to our knowledge of, and to awaken interest in, the theory of disease processes.

In these pages will be found admirable discussions regarding cardio-vascular derangement, the pathology of the blood, infection and immunity, morbid conditions impairing respiration, disorders of digestion, disturbances in nutrition and metabolism, including diabetes and gout. A chapter is devoted to the pathology of fever, and another to alterations in the urinary secretion. The concluding section is a fairly satisfactory presentation of nervous disorders. The value of the book is considerably increased by references which are given, but the almost entire absence of illustrations and diagrams (for there are only five figures given) we consider regrettable. The translator has done his work well. Perhaps wisely, a literal translation has not been attempted. Certain sections have been abbreviated and some of the material rearranged, but throughout the spirit of the original work has been loyally maintained. Some few additions on such subjects as blood pressure, surgical shock and hæmorrhagic pancreatitis have been made, and occasionally exception or amplification of the author's views have been made by the translator, but in such cases these are indicated. The original edition is fruitful in references to German literature. Many of these have been curtailed, and some English references have been added, but we venture to think that the work of clinicians and experimentors in this country have not received adequate attention. But this, of course, is no new feature in works of Teutonic origin. All concerned in the production of this work in its English, or should we not rather say American, dress, are to be congratulated, and we commend it to the serious study of all scientific physicians and those preparing for the higher examinations.

(a) "The Principles of Clinical Pathology."—A Textbook for Students and Physicians, by Dr. Ludolf Korchl, ordinary professor and director of the Medical Clinic in Strasburg. Authorised translation from the third German edition, by Albion Walter Hewlett, M.D. Instructor in Clinical Medicine at the Cooper Medical College, San Francisco; pp. 504. Philadelphia. J. B. Lippincott Co., 1905. Price 21s. net.

YELLOW FEVER. (a)

DR. HOWARD KELLY has found time in the midst of his strenuous life to carry through a task which should earn him the gratitude of all Anglo-Saxon medical men, namely, the writing of a biography of Walter Reed, army surgeon, bacteriologist, and discoverer of the intermediate host of yellow fever. To British medical men in particular this book will be acceptable, because so hasty is the advance of knowledge and so fleeting are men's recollections of the individuals who have established its landmarks, that the true romances of scientific achievement all too easily escape the attention they deserve. And this history of the work of the Yellow Fever Commission in Cuba is a romance in real life, none the less poignant because it was played out at a distance from the haunts of men and entailed a painful list of casualties among the bright and noble spirits which animated it. There is no devotion so complete, so utter, as that which knowingly and in cold blood offers life and health for the benefit of mankind, and of such could there be a finer example than was presented by the two young private soldiers who, with full knowledge of the almost certain consequences, offered themselves as subjects for the bite of infected mosquitoes? Major Reed did them no less than justice when he touched his cap and said, "Gentlemen, I salute you." Nor should we forget the calm self-sacrifice of Dr. Carroll and Dr. Lazear; the former was the first subject of an experimental mosquito bite, and the latter lost his life in the cause. It is good that all men, and especially all medical men, should learn and cherish in their memories their noble deeds. Dr. Kelly quite clearly establishes Walter Reed's claim to be the first to demonstrate the actual part played by the mosquito in the dissemination of yellow fever, first by his patient destructive criticism of the work of Sanarelli and others, and, secondly, by his constructive experiments. The Britisher may feel a little glow of patriotic pride when he reflects that without Mauser and Ross there would have been no Reed, but he will never be tempted to withhold his tribute of homage from the discoverer of a verity so pregnant with human happiness as that which Reed established. By no means the least valuable part of the book is that which deals with the previous history of yellow fever and the evolution of the idea of insect-transference, and in it full justice is done to the work of all Reed's predecessors. When, too, alongside it we read of the many definite facts demonstrated by the Yellow Fever Commission, and the immediately satisfactory results that ensued from prophylactic work founded upon the conclusions, we feel that this is a book of substantial and enduring worth. For it we have heartily to thank Dr. Howard Kelly, to whom we doubt not its preparation was a labour of pleasure and a labour of love; but he will none the less be gratified to know that his tribute to the memory of his dead friend will find an echo in the hearts of humble workers in the same field on this side of the Atlantic.

(a) "Walter Reed and Yellow Fever." By Howard A. Kelly, Professor of Gynecological Surgery, Johns Hopkins University. New York: McClure, Phillips and Co. 1906.

TUBERCULOSIS OF THE LUNG (*a*).

THIS unpretentious volume is a translation of the first two sections of Dr. Turban's "Beiträge zur Kenntnis der Lungen-Tuberculose," which was issued in 1899. Dr. Morland has done well in preparing the most important portion of this valuable work in a form acceptable to English readers. The translation has been undertaken with the author's co-operation, and additions and corrections have been made so as to adequately express the writer's latest views. The book consists of two papers, originally distinct. The first is "On Early Tuberculosis of the Lung and the Classification of the Disease into Stadia"; the second deals with "Physical Examination in Tuberculosis of the Lung." The title of the translation is therefore seen to be something of a compromise as well as a convenience. There is much in these pages which will be of great interest to the expert in consumption. The section which deals with classification of cases is highly suggestive, but the division adopted is not one likely to commend itself to English readers. Dr. Turban would have us tabulate cases in three groups:—(1) Disease of slight severity, affecting at most one lobe or two half lobes; (2) Disease of slight severity, more extensive than (1), but affecting at least two lobes; or severe, and affecting at most one lobe; (3) All cases of greater extent and severity than (2). It is certainly true that a uniform grouping of cases is most desirable if we are to attain to any satisfactory comparison of results as recorded in the reports of the many institutions devoted to the treatment of the consumptive, but Dr. Turban's suggestion is hardly likely to be adopted. His so-called "Schema" for comparative statistics offers but little that is new or likely to be helpful. The portion of the work of greatest interest and value is that which deals with the physical examination of the chest of the tuberculous, and here, very justly, insistence is made on the importance of certain signs which are only too often overlooked or neglected. More than six pages of bibliography appear, but we are sorry to see that English writers are most inadequately, and, as we think, unfairly represented. We could have wished that the translator had included the results of Dr. Turban's lengthy experience of sanatorium treatment at Davos, which, at the present time, when the value of institutional treatment is being much discussed in this country, would have been of scientific interest and practical service.

NEW WORKS ON CONSUMPTION.

THE first of these volumes is, as its title (*a*) suggests, a comprehensive exposition of the inter-relations of civilization and consumption, and a detailed discussion of the influence of this fell malady on man's life and human affairs generally. It is no mere academic treatise or medical handbook, but a medico-sociological study which should appeal to the thoughtful layman as much as to the medical practitioner and health officer. The author has undertaken no light task in attempting to enlist the attention of both physician and layman, but even a cursory glance at these attractive pages will afford evidence that no small measure of success has resulted. The scope of the work is extensive; economic, legislative, sociological, humanitarian, as well as purely hygienic: pathological, and clinical features of the problem are dealt with. In some instances the presentation has been incomplete and even superficial, but where so wide a field has had to be covered, a measure of insufficiency is unavoidable. The author writes with true American verve. His style is lucid and incisive and intensely human in its sympathy, and not lacking in the saving element of humour. The work is most informing and highly suggestive and the striking illustrations are in some cases almost sensational in their tragic and insanitary features. Dr. Huber wanders into many fascinating byeways, as, for instance, where he details the effects of consumption on literature and art, or where he discusses the psychic element in the disease. A particularly valuable section of the work will be found in the appendices, where, amid much of practical service, appear lists of American Societies and Committees for the prevention of tuberculosis. The work is one which should have an extensive circulation not only in the land of its birth, but among all English-speaking people. Its perusal should accomplish much in stimulating thought and energising action among those responsible for individual and collective effort in stemming the death-dealing tide of this devastating scourge.

Sir William Broadbent says, in his introduction to this unpretentious monograph (*b*) (second on our list): "The economic, the philanthropic, the preventive, and the educational [aspects of the subject] are discussed by Dr. Bardswell in an eminently practical spirit, and the whole book is the outcome of experience inspired by enthusiasm and guided by common sense." We may add that the major part of the volume is a detailed description of twenty-five cases carefully observed and thoroughly investigated by the author at the Sheffield Royal Infirmary and the Mundesley Cottage Sanatorium. In addition to the clinical data, there are interesting notes on the social and economic conditions of each patient. The most suggestive portion of the work is the all too short section devoted to conclusions, and based as they are on so small a number of cases, they can hardly be considered as conclusive. Dr. Noel Bardswell thinks that "of all admissions to a sanatorium for the working classes we may expect permanent restoration of health and normal working capacity in 41.7 per cent. Death in the course of from two to five years after discharge in 41·7 per cent. Some degree of permanent restoration of health and capacity for work in 16·6 per cent." Although lacking in originality and presenting no statesmanlike grasp of the problem, the monograph is interesting, and to those who have studied the subject "on the spot" will be suggestive and helpful, although many will differ from the author on important points. As a personal contribution to a problem of great magnitude, it is of considerable merit, but it does little to advance our knowledge and leaves us still in the experimental stage. The title is not particularly happy and is not free from the charge of being misleading. Half-a-guinea seems an unusually high price for a small work of 200 pages with three illustrations of the grounds of the Sheffield Infirmary and a picture of the Mundesley Cottage Sanatorium.

The third work (*c*) is a diminutive volume written in a simple and unpretentious style of instruction for the home guidance of the consumptive patient who is seriously directing his life towards recovery. It is a concise, clear, and dogmatic presentation of rules which are essential in the conduct of the hygienic treatment of pulmonary tuberculosis. Twenty-five rules are given, which on the whole are judicious and wisely expressed. The importance of temperature as a guide is rightly insisted on, and suitable charts for the use of the patient are given. The little manual is well intentioned, and medical practitioners may wisely provide their consumptive patients with a copy, for they may be assured that the information is not only reliable, but is set forth in simple language which can be readily understood.

(*a*) "The Diagnosis of Tuberculosis of the Lung," with Special Reference to the Early Stages. By Dr. K. Turban. Translated by Egbert C. Morland, M.B., B.Sc. Lond., with an Introduction by Sir Dyce Duckworth, M.D., LL.D., F.R.C.P. Pp. viii., 135. (London: John Bale, Sons and Danielsson, Ltd., 1905. Price 5s.)

(*b*) "Consumption: Treatment at Home and Rules for Living." By H. Warren Crowe, M.D. Pp. 32, with Charts. Bristol: John Wright and Co. 1906.

(*c*) "Consumption: Its Relation to Man and His Civilization, its Prevention, and Cure." By John Bessner Huber, A.M., M.D., Visiting Physician to St. Joseph's Hospital for Consumptives, Philadelphia, etc. Pp. 536, with 131 illustrations. Philadelphia and London: J. B. Lippincott Company. Price 15s. net.

(*a*) "The Consumptive Working Man: What Can Sanatoria Do For Him?" By Noel Dean Bardswell, M.D., M.R.C.P., F.R.S. Edin., Medical Superintendent King Edward VII. Sanatorium. Pp. 202. London: The Scientific Press, Limited. 1906. Price 10s. 6d. net.

MEDICAL NEWS IN BRIEF.

A Split in the Anti-Vivisection Camp.—The Vivisection Inquiry.

We reproduce the following interesting letter published by the Editor of *The Tribune*.

"SIR,—In a recent issue you give some prominence to the views of the Hon. Stephen Coleridge on the above subject. Had these views been given merely as representing the attitude of Mr. Coleridge himself, or of the National Anti-Vivisection Society, of which he is both hon. secretary and treasurer, they might be allowed to pass. But when Mr. Coleridge's views are put forward as those of "the Anti-Vivisection Society," and when reference is made to him as "the leader of the Anti-Vivisectionists," it is surely necessary that someone should, on behalf of the many thousands who disagree with his policy, publicly decline to allow Mr. Coleridge to speak for them, and to claim a position to which he is not entitled.

"The 'points' given by Mr. Coleridge to the Royal Commissioners proclaim quite unmistakably that—at present—he is not an anti-vivisector at all, but merely one who wishes to see vivisection carried on under slightly different conditions. For these points amount to the suggested prohibition of the following:—

"(1) The use of the drug curare.

"(2) Experiments involving protracted agony.

"(3) Experiments performed for the mere acquisition of knowledge.

"(4) Demonstrations before students.

And they include the sanction of the following:—

"(1) All painful experiments in which the agony is not 'protracted,' provided they are performed for the purpose of serving the human race.

"(2) The system of medical inspection at present in vogue, whereby one vivisectionist is set to watch another.

"Now it is obvious that the distinction between experiments for the advancement of knowledge and experiments for the service of humanity cannot be drawn, inasmuch as a vivisector can always argue that knowledge not immediately and demonstrably useful may prove useful under certain contingencies in the future. It is also obvious that if an advanced scientist is to be allowed to vivisect, he must receive the necessary training when a student. Two of Mr. Coleridge's points are thus proved impracticable. I should not, however, have ventured on this criticism were it not for the unfortunate circumstance that opponents of the entire system of vivisection have been misrepresented by the supposition that they follow a 'leader' who has made a public statement suggesting to the Commissioners that they should not oppose painful experiments on animals except when the agony is protracted and the object useless.—Yours, etc.

"B. E. KIDD,
"Secretary, British Union for Abolition of Vivisection."

'32, Charing-cross.'

Diphtheria Epidemic at Melbourne.

AN important conference between the Parochial Committee and the medical officer of health, the local doctors, and others, was held last week at the Council School, Melbourne, Notts., concerning the prevailing epidemic of diphtheria and the general sanitary condition of the town. There were present—Lord Walter Kerr, Mr. W. Garratt, Mr. Bagwell, Dr. Hogg (medical officer of health), Drs. Moore and Tredinnick, Mr. Mallalieu, J.P. (chairman of the Shardlow Rural District Council). Mr. Adcock, who presided, explained that the conference was called to devise, if possible, an effectual way of stamping out the epidemic.

Dr. Hogg said that Melbourne had suffered for some time from scarlet fever, which was now abating, but they were threatened with an outbreak of diphtheria. There had been nine cases in the past fortnight. It was fortunate they were of a mild type, but this made it the more difficult to stamp out, because some children might have it so slightly that it would not be discovered until it had developed. They went to school within a day or two of having a sore throat, and thus spread the infection. As far as house sanitation was concerned, Melbourne compared favourably with any other place in the district. It was now generally recognised that diphtheria was spread by direct contact, although defective drainage had a predisposing influence in spreading it.

Considerable discussion followed, the general feeling being that the gullies were not flushed sufficiently often, and it was eventually decided to recommend the Parochial Committee to draw up a petition, to be signed by the ratepayers, asking the District Council to allow the Parochial Committee to undertake the flushing of the sewers, and refund the cost thus incurred.

[The above congress is of importance, as it is held at the outset of an outbreak, and not deferred, as so often happens, until the epidemic has attained formidable dimensions.—ED. M.P. & C.]

The Extirpation of Malaria.—Liverpool and the Campaign in Greece.

ON the 17th inst., under the auspices of the Liverpool School of Tropical Diseases, a gathering of gentlemen concerned in the anti-malaria campaign in Greece took place at the University Club, Liverpool. The guests were invited to lunch by Sir Alfred Jones, chairman of the School, to meet Professor Dr. Savas, of the University of Athens, and physician to the King of Greece. The chair was occupied by the Lord Mayor of Liverpool (Alderman Joseph Ball).

Alcohol as Medicine.—Local Government Board View.

AT the meeting of the Epping Board of Guardians last week, Dr. Fuller, medical officer to the Local Government Board, on behalf of that body, severely criticised the expenditure of one of the district medical officers of £16 15s. 4d. for the half-year on wines and spirits. He said that the Local Government Board had always agreed that the use of alcohol was not necessary in the treatment of diseases, and they wished to impress on boards of guardians those views. In the case in question, the situation entirely arose through the pronounced views of a certain medical man in favour of the use of spirits. It was decided to write to the Local Government Board in order, as the chairman remarked, to get these views in "black and white."

Arbroath Water Works.—The Typhoid Outbreak.

AT a recent meeting the Brechin District Committee had before them a joint report from Dr. Dewar, Medical Officer, and Mr. J. Anderson, Sanitary Inspector, on the outbreak of typhoid fever among the workmen engaged at the construction of the Arbroath Corporation reservoir at Glenogil. The report stated that, in consequence of several cases of undoubted typhoid fever having occurred among the workmen, and a number of cases having occurred in the lower valley of the Noran, a district which for many years had been exempt, and these cases being exclusively confined to those who drank the Noran water, or were indirectly infected from those who had done so, there was strong suspicion that the disease

had been introduced by the labourers at Glenogil Water Works, and disseminated by the pollution of the Noran stream. Their inquiries showed that generally speaking, the huts were clean and fairly well ventilated; the beds also, as examined, were as clean as could be expected. The disposal of the slop water was not satisfactory. Originally intended to be filtered through gravel, it was now reaching the Keillor Burn in an impure condition at several places. Refuse of all sorts was strewn over the ground in the neighbourhood of the huts. Owing to the configuration of the district it was impossible to suggest an alternative or preferable site for the huts. No fresh case had occurred for three weeks, and they recommended certain improvements on the present sanitary arrangements.

Tropical Medicine Research.

HIS MAJESTY the King of the Belgians has recently demonstrated his interest and approbation in the work of the Liverpool School of Tropical Medicine by decorating Professor Ronald Ross, C.B., F.R.S., Professor R. Boyce, F.R.S., etc., and Dr. J. L. Todd. The honour thus conferred upon them is not to be allowed to pass unnoticed locally, for the recipients are to be entertained at lunch by the Lord Mayor, at the Town-hall, on Monday next, and invitations have just been issued to a numerous company to meet them.

Death under Chloroform.

DURING a dental operation at a well-known Liverpool dentist's last week, a lady patient unfortunately succumbed under the anæsthetic. At the inquest subsequently held, it was proved that the drug was carefully and skilfully administered, and that no blame was attachable to the administrator or the operator, and a verdict in accordance with the evidence was returned.

Alleged Fraudulent Westminster Collector.

HUGH BEATON GORDON, 35, who gave an address at Atherfold Street, Clapham, and described himself as a debt collector, was charged last week on a warrant before Mr. Horace Smith at Westminster Police Court, with fraudulently converting a sum of over £10, entrusted to him, to his own use and benefit. The prosecutor, a medical man, of Upper Kennington Lane, about twelve months ago responded to a circular sent by prisoner to medical men offering to collect outstanding accounts. There was to be a quarterly settlement, but it was alleged that sums which prisoner obtained never found their way to the prosecutor, and that his letters, though not returned, remained unanswered. Detective-sergeant Long said that he had had great difficulty in tracing the prisoner, and that it was only by a ruse that he was brought back to London. No doubt there would be other charges against him. Prisoner was remanded and bail refused.

A Sidelight on Medical Education.

THE examinations for admission to the Army, Navy, and Indian Medical Services are especially interesting in view of the fact that they are the only competitive medical examinations which exist. Since the spring of 1902, altogether 693 men have contested for 434 commissions. Competition has been keenest for the Indian Medical Service and least keen for the Navy. English Candidates have greatly preponderated, and England has had the least proportion of failures.—*Tribune.*

Royal College of Surgeons of Ireland—Post-Graduate Course.

The second post-graduate course of the year commenced on Monday last, the 24th inst., and continues daily until October 3. The various hospitals at which classes will be held include Stevens', the City of Dublin, Sir Patrick Dun's, the Adelaide, the Meath, the Richmond, the Rotunda, the National Maternity, the Coombe, the Mater, and the Victoria Eye Hospitals, and other special hospitals and institutions. All information regarding the hour of classes, etc., can be obtained from Professor Fraser at the College.

Royal Misericordiae Hospital, Dublin.

A dinner of the past and present students of this hospital will be held at the Shelbourne Hotel, at 7.30 p.m., on Saturday, October 6th, when Sir Christopher Nixon, Bart., will be entertained by the Medical Board. Dinner tickets, with wine, 21s.; without wine, 10s. 6d. each person. Past students may invite not more than one guest each. Cards of invitation will be sent to guests by the secretary. Past or present students who desire to be present should send their names, with the names and addresses of their guests, and the necessary subscriptions, to Dr. Martin Dempsey, 35, Merrion Square, Dublin. No subscription will be received and no withdrawal accepted after 9 a.m. on Thursday, October 4.

Royal Academy of Medicine in Ireland.

The Annual General Meeting of the Royal Academy of Medicine in Ireland will be held in the Royal College of Physicians on Friday, October 12th, at 4.30 p.m., when the Annual Report will be submitted, and the officers and members of Sectional Councils will be elected. Nominations of candidates for office, whose sanction has been obtained, must be sent to the General Secretary in writing not later than Tuesday, October 2nd. The offices for which candidates may be nominated are: President, General Secretary and Treasurer, Secretary for Foreign Correspondence, President of the Section of Anatomy and Physiology, Member of Council in the Sections of Medicine, Surgery, Obstetrics, Pathology, Anatomy and Physiology, and State Medicine.

University of Durham.

THE following candidates have passed the Second Examination for the Degree of Bachelor in Medicine:—John Pritt Jackson, in anatomy, physiology, and materia medica, with second-class honours. Pass List: Alexander Hay Bower, Leonard Foster Browne, John George Campbell, B.A., Harold Alexander Cooper, Reginald Cyril Herbert Francis, Patrick Albert Galpin, Raghunath Vithal Khedkar, L.R.C.P.&S., L.F.P.S., G. Ernest Percy Martin, Theresa de Gournay Miller, Ruth Nicholson, Robert Raffle, Charles Elias Reindorf, Harold Widdrington Sykes, George Huntly Wood.

SIR WILLIAM TRELOAR has called attention to his Crippled Children's Fund, the aim of which is to provide a Christmas banquet for London cripples at the Mansion House. To those who cannot attend hampers are sent. This most excellent charity is supported yearly by King Edward. It is specially interesting to medical men to note the following:—

The Fund which is raised usually provides a balance to be expended in surgical instruments, artificial limbs, invalid chairs, and other benefits greatly appreciated by the suffering little ones.

PROFESSOR BOEHNER, of the McGill University, reports that an epidemic of measles has broken out among the Indians in Northern Quebec. Forty are dead. He adds that food is scarce.

WE regret to report the accidental death of Major Cecil Birt, of the Royal Army Medical Corps. Deceased, who was stationed at Chatham, met with a bicycle accident near Reading, and sustained injuries that proved rapidly fatal.

GEORGE MORGAN, a medical student, was on Monday last committed for trial at the Central Criminal Court for obtaining money under false pretences from Dr. Eason, of Guy's Hospital, Mr. Dickey, house surgeon of the Miller Hospital, Greenwich, and others.

DR. HENRY GERVIS, of Brighton, has been unanimously elected Mayor of that important borough for the ensuing year.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS. ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT SURGICAL LITERATURE.

On the Technique of Operations on the Central Nervous System.—Sir Victor Horsley (*Brit. Med. Journ.*, August 25th, 1906) points out that the prominent characteristic of intracranial disease is its liability to produce optic neuritis. It may concomitantly cause severe headache and vomiting. The most important factor in the production of optic neuritis is the intracranial tension. As soon as optic neuritis (not of toxic or anæmic origin) is diagnosed, palliative surgical treatment at least should be undertaken as soon as possible, so as to prevent complete atrophy and total blindness. In rare instances, the neuritis may begin to subside after even the first stage of opening the skull: but it is, as a rule, necessary to make a free opening into the dura mater to effect this purpose. One reservation must be made, that is, in cases where the tumour involves the optic tract. Optic neuritis usually commences on the side of the lesion. In the consideration of the details of all operative procedure the posture of the head is a most important one. The head should be elevated on a suitable head rest to diminish the pressure on the venous sinuses, and the shoulders slightly raised, so that the glottic respiration is not interfered with. The author always employs chloroform as an anæsthetic, using Vernon Harcourt's regulator for its administration. As a rule, 2 per cent of chloroform in the air respired is given for about five minutes before the incision of the skin and reflexion of the flap, which constitutes the maximum pain period of the operation. The bone may be removed at 1 per cent. As the dura is a sensitive membrane, the dose should be somewhat raised just previous to its incision. As soon as the dura is opened the encephalon can be dealt with without causing any pain, and the operation is done under less than ·5 per cent. of chloroform. After the encephalic region is dealt with the percentage always should be raised to ·7 or 1 per cent. to provide for the skin sutures. It is necessary during all operative procedures on the skull and its cavities to prevent cooling by radiation from the brain exposed in the wound, as well as from the body surface generally. The wound should therefore be constantly irrigated with a solution of 1 in 10,000 of sublimate or with saline, at a temperature of 115°. This hot lotion also serves the purpose of arresting capillary and arterial hæmorrhage. As regards hæmorrhage, the first general principle is the recognition of the fact that as few vessels as possible should be obstructed, to prevent softening of the brain areas supplied by them. Where it is necessary to remove large portions of the brain, the branches of vessels to be divided should be severed as far as possible from the trunk. Tying the carotid artery with the view of producing a large control of the blood flow from the cerebral arteries is a measure to be avoided. Serious and even fatal secondary œdema and softening have often followed this procedure. Tying all the arteries around the lesion before extirpating it is the best plan. The incision in the brain should be commenced below and carried upwards and towards the mesial plane. Hot irrigation is the safest and easiest method of arresting capillary oozing. The author is also in the habit of controlling capillary and venous oozing by requesting the anæsthetist to direct a stream of oxygen gas through the air inlet of the Harcourt regulator, and so quickly abolish any asphyxia. Bleeding from veins in bone can be with certainty arrested by plugging with wax. Wounds in sinuses must be closed with a fine lateral suture on a round needle. Sir Victor Horsley considers that shock can be in a great part avoided by dividing the operation into two stages, the interval between them being about five days. The first stage consists of the opening of the skull, the second of the opening of the dura mater and removal of the lesion. The best method of opening the skull is by first removing a trephine disc, then marking with a large saw the area to be removed and finally cutting away the bone with a large bone forceps. In reference to sepsis the author asserts that the less drainage is employed the better, and that every effort should be made to close the skin wound as early as possible. In discussing general consideration, the method of reaching tumours of the base is described. This is best done by displacement of the brain, by inserting a flat spatula beneath the brain between the more important emissary veins which anchor the cerebral hemisphere to the dura mater at various points. Sir Victor Horsley makes the following general deductions on the question of the surgical treatment of malignant disease of the encephalon: (1) That operation should be resorted to as early as possible; (2) the tumour should be, if possible, freely exposed and examined, and extirpated with surrounding tissue; (3) that if it cannot be removed with ut undue interference with important or essential structures there remains some possibility of the tumour undergoing retrogression in a certain number of cases. S.

A Series of Cases in which Collections of Stones formed in the Prostatic Urethra. — Morton (*Brit. Med. Journ.*, August 11th, 1906) reports three such cases in all of which the presence of the stone was associated with a stricture of the urethra, and thus the passage of the stones out of the urethra was obstructed. The stricture was not very tight in any of the cases, and was easily dilated to a considerable extent. The prostatic uretha was greatly dilated in each case, so that prostatic tissue could not be recognised. The stones were mostly phosphatic, and there was no reason to believe that they were originally formed in the prostate. The author considers that the urine remaining in the dilated urethra after micturition deposited phosphates and so formed calculi. The prostatic urethra was so dilated in one of the cases that by pressure on it a stream of urine could be forced out of the perineal fistula which remained after operation. In none of the cases was the stricture just in front of the prostatic urethra. In one case it was scrotal, in another at the junction of the scrotum and penis, and in the third quite near the meatus. Yet, as one would expect, there was no general dilatation behind the stricture. Treatment is unsatisfactory. In Case I., stones were removed by incision six times. Once a stone which caused retention was removed by forceps. The patient frequently passed other stones. Perineal section to remove the stones, together with dilatation of any stricture or strictures is clearly indicated, also to keep the stricture well dilated, so that stones may have a chance to pass when small. In one case the author after considerable difficulty succeeded in forming a permanent perineal fistula in order that urine might not remain and deposit in the dilated part of the urethra, but even this has not stopped the formation of stones for the patient frequently passes small ones.

Antipyrin Amaurosis.—F. C. Hclz (*Archives of Ophthalmology*, Nos. 2 and 3, 1906) relates a case in which a man, æt. 33, who was a "martyr" to migraine, took twenty-six five-grain tablets of antipyrin in forty-eight hours. During this time his sight failed until at the end of the forty-eight hours it was almost extinguished. Under iron internally and pilocarpin subcutaneously, the patient recovered full vision. Three other cases of this form of amaurosis have been recorded. In one, a lady took fifteen grains and in five minutes was perfectly blind. The blindness lasted

one minute and she was quite well in three days. In a second case, a lady took fifteen grains of the drug after a meal, and in three minutes was down with violent headache, tinnitus, vertigo, palpitation, dyspnœa, and cold perspiration. In twenty minutes she lost her sight, and the blindness lasted thirty minutes. In the third case, a man had been taking three tablets of antipyrin (ten grain pro dose) at one hour intervals, when he had an attack of migraine, which was about every week. After several months his sight became blurred, but there is no mention as to how long it remained so. It would seem that antipyrin has no serious effect on the eye, if taken only occasionally, and in moderate doses. But if large doses are taken in a short time, blindness is liable to set in suddenly, and run to profound amaurosis which may last for many months. M.

A Case of Inoperable Cancer Treated with a Bacterial Vaccine of Neoformans. — Spicer and Wright (*Journ. of Laryn., Rhin., and Otology*, June, 1906) record a case of cancer in a Balaclava veteran, æt. 75, in which the tumour occupied the site of the left tonsil, fauceal pillars, side of the tongue, and extended down the wall of the pharynx. The faucial isthmus was so blocked that laryngoscopy with the smallest mirror could not be practised. The tongue could not be extruded. The surface of the growth was studded with bloated fungous granulations imbedded in copious fœtid fluid. There was a large mass of hard swollen glands behind angle of jaw, dysphagia, and much pain in left side of head and ear. Professor Wright treated the case by a vaccine of Micrococcus Neoformans. Favourable changes commenced at once and continued to increase for five or six weeks, after which matters came to a standstill. The favourable changes were: Shrinking of the faucial mass rendering laryngoscopy possible, lessening of ulcerated surface, which became like a healthy granulating surface, loss of fœtor, disappearance of dysphagia and pain, the tongue became less rigid, and the external glandular mass shrunk enormously. Although a cure is not claimed, the authors consider the improvement marvellous both locally and in the patient's general condition, and look upon the case as one of good augury for the influence of the treatment. Professor Wright's account of Doyen's Micrococcus Neoformans and of the *rationale* of the treatment is interesting. He states that Dr. Spicer's case is one of a batch of five where he inoculated the M. neoformans vaccine in which there was a striking result. Two have died; one has remained stationary, while another shows marked improvement. M.

The Treatment of Cancer of the Rectum.— Samuel Gant discusses under three headings (*New York Med. Journ.*, August 18) the treatment of rectal carcinoma. The treatment may be palliative, surgical palliative, or radical operative treatment. The most important feature in palliative treatment is the prevention of obstruction or its relief if it should already have occurred. This is accomplished by diet, the use of such remedies as olive oil, castor oil, salts, and such drugs as will soften or liquify the fæces, so that they may easily pass the constriction. Where fæcal impaction has occurred, purgatives are contra-indicated, copious enemata should be given through a colon tube, If this fails, the fæcal mass must be broken up with the finger or a scoop, and washed out. The bowel should be frequently washed out with some antiseptic solution, to prevent secondary ulceration of the mucous surface taking place. By means of the X-ray much can be accomplished in diminishing pain, retarding the growth of the neoplasm, and in prolonging life; but in the writer's hands it has had no curative effect whatever on cancers of the rectum. The surgical palliative measures for the relief of rectal or sigmoid carcinoma are, in the order of their importance, colostomy, proctotomy, curettage, and forcible divulsion. Curettage should only be resorted to if the growth is within three inches of the anus. Proctotomy and forcible divulsion can only be of use when the disease is situated at or just above the anus. In all cases where the growth is not fixed to adjacent structures, where there are no metastases in other organs, and where the patient is not extremely debilitated, the author believes that a radical operation should be done. The operation he performs is either superior or inferior proctectomy, the former in the case of high growths, the latter if the cancer is situated low down in the bowel. In inferior proctectomy the soft parts only are divided, while in the superior operation the coccyx and a portion of the sacrum are removed to allow of freer access to the bowel. The mortality for the inferior operation is about 7 per cent. and for the superior about 21 per cent., while about 16 per cent. of the cases are absolute cures. The writer concludes by stating that after a personal study of more than 200 cases of rectal cancer, treated by palliative surgical palliative procedures, and the radical operation, he unhesitatingly advises complete extirpation of the growth when possible, because this is the only procedure which tends to relieve suffering, and offers to the patient a chance of permanent recovery from his affliction. G.

Gastrostomy.—E. Tavel (*Zentralblatt fur Chirurgie*, June 9) calls attention to a new method of performing gastrostomy. The ordinary operation has two faults, in that the stomach is left in contact with the abdominal wall, which must be hurtful to the functions of the organ; in the second place the permanent opening into the stomach is too small to permit any but soft food-stuffs being introduced; for these reasons the author performs the following operation: A piece of the jejunum is isolated about five inches in length, divided between clamps, care being taken not to interfere with its blood supply; this loop is held to one side, while an end-to-end anastomosis is made between the cut ends of the jejunum. An opening is then made through the mesocolon, and the isolated portion of gut brought through this; the distal end of the loop is then implanted in the anterior wall of the stomach, and the proximal end attached to the abdominal wall. The operation has, in the author's opinion, only one disadvantage, that is, that it takes longer to perform than the ordinary methods of gastrostomy. G.

The Treatment of Cancer of the Stomach. — In a lecture on this subject, Mayo Robson (*Lancet*, August 18) deals first with the diagnosis, and then the treatment of gastric carcinoma. He believes that he has now collected sufficient evidence to prove the following: (1) How desirable it is to make an early diagnosis of cancer of the stomach, in order that a radical operation may be performed at the earliest possible moment. (2) That it may be needful to perform an exploratory operation to complete or confirm the diagnosis. (3) That such an operation may be done with little or no risk in the early stages of the disease. (4) That even where the disease is more advanced and a tumour perceptible, an exploratory operation is, as a rule, still advisable in order to carry out radical or palliative treatment. (5) That where the disease is too extensive for any radical operation to be done, the palliative operation of gastro-enterostomy, which can be done with very small risk, may considerably prolong life, and make the remainder of it much more comfortable and happy. (6) That some cases, thought at the time to be cancer, too extensive for removal, may after gastro-enterostomy clear up and get completely well. (7) That in cases of disease of the cardiac end of the stomach too extensive for removal, the operation of gastrostomy may considerably prolong life, and prove of great comfort to the patient by preventing death from starvation. (8) That even where the disease is too extensive for removal, or for a gastro-enterostomy being performed with a fair chance of success, the operation of ejunostomy may prove of service to the patient. (9) That where a radical operation can be performed the thorough removal of the disease may bring about as much relief to the patient as does the operation for the removal of cancer of the breast, uterus, and other organs of the body, and that in some cases a complete cure may follow. G.

NOTICES TO CORRESPONDENTS, &c.

☞ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to 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 proofs.

CONTRIBUTORS are kindly requested to send their communications if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

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.

EUCAINE.—Naphtholum camphoratum is not without danger as a local anæsthetic. Several fatalities have been recorded. Probably it is only dangerous in oily solutions.

DEVONIAN.—1,085 cases were notified in Bristol last year. There were 39 deaths, giving a case mortality of 3·5 per cent.

ATBARA.—The commonest specie of locust in Khartoum is pœciliocerca hierogliphica. It lives chiefly on the Ushen plants.

THE METHYLENE BLUE REACTION IN ENTERIC FEVER.

ERRATA.—In Dr. Rolleston's paper which appeared in our last week's issue, the following corrections should be made:—In seventh line, page 303, "Very mild cases of co ivalescenee" should be "Very mild cases or convalescent." On page 304, line 33, for "I was employed," read "I employed it."

HATLESS WOMEN.

DEAR SIR,—*Re* "The Hatlessness of Womankind" (MEDICAL PRESS AND CIRCULAR, September 5th), it may possibly interest you to observe the different impressions created in men's minds by their various professional training, &c., *vide* Corinthians, Chapter XI., and contrast with your article under the above title.

Yours truly,
DUBLIN.

[The writer of the paragraph dealing with the hatlessness of women was aware of the text on the literal interpretation of which the objection of various clergymen to feminine hatlessness in church is founded.—ED. M.P. and C.].

LYMPH.—A paper on the subject of the ability of vaccine lymph to stand very low temperatures was published by the Local Government Board on July 31st of this year.

SENEX.—"The Garden of the Unforgotten" is described in Sir Frederick Treves' book, "The Other Side of the Lantern."

PRESCRIPTION.—The proper phrase would be: "Cochlearia duo ampla omni horâ capienda dome singultus cessavérit." But prescription latin does not pretend to be very elegant.

BACTERIA.—See paper by Metchnikoff, "Zur Immunitätslehri." Congr. f. Inn. Med., 1892, 282.

MR. G. G. MONCK.—The number of this journal containing the lecture is out of print, but a reprint in pamphlet form may now be had through your bookseller. Price, 1s.

S. J. R. has not sent his name and address; we are, therefore, unable to return his MS. His effusion is amusing and would doubtless be accepted by one of the lay weeklies, but it is not of sufficient professional interest for the columns of a medical journal.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, SEPTEMBER 26th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—10 a.m.: Diseases of the Throat, Nose, and Ear. Diseases of Children. 2 p.m.: Medical and Surgical Clinics. 2.30 p.m.: X-Rays. Operations.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. H. L. Barnard: Clinique. (Surgical.)

THURSDAY, SEPTEMBER 27th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—2 p.m.: Medical and Surgical Clinics. 2.30 p.m.: X-Rays. Operations. Diseases of the Eye.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical).

FRIDAY, SEPTEMBER 28th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—2 p.m.: Medical and Surgical Clinics. Diseases of the Throat, Nose, and Ear. 2.30 p.m.: X-Rays. Operations. Diseases of the Skin.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. H. Eason. Clinique. (Ear.)

SATURDAY, SEPTEMBER 29th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—10 a.m.: Diseases of the Throat, Nose, and Ear. 2 p.m.: Medical and Surgical Clinics. 2.30 p.m.: X-Rays. Operations.

Vacancies.

Aberdeen Royal Asylum.—Senior Resident Assistant Physician. Salary £200 per annum. Applications to Dr. Reid, the Medical Superintendent.

Bradford Royal Infirmary.—House Surgeon. Salary £100 per annum, with board and residence. Applications to Edmund Forster, Secretary.

City of Liverpool.—Assistant Medical Officer of Health. Salary £250 per annum. Applications to Edward R. Pickmere, Town Clerk, Town Clerk's Office, Liverpool.

City of Liverpool.—Infectious Diseases Hospital.—Assistant Resident Medical Officer. Salary £120 per annum, together with board, washing, and lodging at the Hospital. Applications to the Chairman of the Port Sanitary and Hospitals Committee, Town Clerk, Municipal Offices, Liverpool.

City of Birmingham Asylum, Rubery Hill, near Birmingham.—Male Assistant Medical Officer. Salary £150 per annum, with furnished apartments, board, &c. Applications to the Medical Superintendent.

Cheshire County Asylum, Macclesfield.—Junior Assistant Medical Officer. Salary £140 per annum, with apartments board (no alcohol), and washing. Applications to the Medical Superintendent.

East London Hospital for Children and Dispensary for Women, Shadwell, E.—Medical Officer for the Casualty Department. Salary £100 per annum. Applications to W. M. Wilcox, Secretary.

Egyptian Government.—Ministry of Education.—Professor of Midwifery and Gynæcology. Salary £400 a year, with private practice. Applications to the Director, School of Medicine, Cairo, Egypt.

Egyptian Government.—Ministry of Education.—Medical Tutor and Registrar to Kasr-El-Ainy Hospital. Salary £400 a year. No private practice. Applications to the Director, School of Medicine, Cairo, Egypt.

Lewis Dispensary and Infirmary and Victoria Hospital.—Resident Medical Officer.—Salary £104 per annum, with furnished apartments, board, coal, gas, washing, and attendance. Applications to Wm. Edwd. Nicholson, Hon. Sec., 213 High Street, Lewes.

St. Pancras and Northern Dispensary, 126 Euston Road.—Resident Medical Officer. Salary £105 per annum, with residence and attendance. Applications to the Hon. Secretary, H. Peter Bodkin, 23, Gordon Street, London.

The Chorlton and Manchester Joint Asylum Committee.—Resident Medical Officer. Salary £150 per annum, with board and residence. Applications to Henry Woodhouse, Clerk to the Joint Committee, Chorlton Union Offices, All Saints, Manchester.

Wolverhampton and Staffordshire General Hospital.—House Surgeon. Salary £100 per annum, with board, lodging, and laundry. Applications to J. Stephen Neil, House Governor and Secretary, Wolverhampton.

Appointments.

BALL, C. R. H., M.R.C.S., L.R.C.P.Lond., Certifying Surgeon under the Factory and Workshop Act for the Hunstanton District of the county of Norfolk.

GLENNY, ELLIOTT T., B.S.Lond., House Physician at the Essex and Colchester Hospital.

IVENS, FRANCES, M.B., M.S.Lond., Honorary Medical Officer for Diseases of Women at the Stanley Hospital, Liverpool.

LAWSON, THOMAS CORNELIUS, M.R.C.S., L.S.A., Medical Officer for the Hartland District by the Bideford (Devon) Board of Guardians.

MCILROY, A. LOUISE, M.D., L.M.Rotunda, Extra-Dispensary Gynæcologist at the Glasgow Royal Infirmary.

MOORE, C. A., M.B., B.S.Lond., House Surgeon at the Stanley Hospital, Liverpool.

MOORE, P. M., L.R.C.P. and S.Irel., Dispensary Officer for the District of Strangford, Downpatrick.

MORRISON, J. W. H., M.B., B.S.Durh., B.Hy., D.P.H., Certifying Factory Surgeon for Blaydon, Whickham, and Ryton Urban Districts, and Medical Officer of Health of the Blaydon Urban District.

PARRY, T. WILFRED, M.B., Ch.B.Liverp., House Physician at the Royal Southern Hospital, Liverpool.

THOMSON, CHARLES SAMSON, M.B., Ch.B.Glasg., House Surgeon at the Sunderland Infirmary.

Births.

FRASER.—On Sept. 16th, at Trevenna, Slough, the wife of Herbert Fraser, M.R.C.S., L.R.C.P., of a son.

LYLE.—On Sept. 18th, at 97 Gordon Road, Ealing, the wife of Frederick W. Lyle, M.D., of a daughter.

NASH.—On Sept. 20, at Oulton House, Accrington, Mary Monica, wife of Edwin H. T. Nash, M.R.C.S., L.R.C.P., of a son.

NEWTON.—On Sept. 21st, at Brook Hill, Sheffield, the wife of Duncan Gray Newton, F.R.C.S., of a son.

STARES.—On Sept. 12th, at The Limes, Swanley Junction, Kent, the wife of C. Lindsay B. Stares, M.R.C.S., L.R.C.P., of a daughter.

Marriages.

BUCKLEY—LANYON.—On Sept. 20th, at St. Peter's, Croydon, James Charles Buckley, M.D., of Nottingham, son of the late Joseph Buckley, of Manchester, to Mabel, youngest daughter of the late John Charles Lanyon, and of Mrs. Lanyon, of "Birchurst," South Croydon.

COOKE—COOPER.—On Aug. 9th, at Ranikhet, India, Philip Geoffrey Benson Cooke, the Bedfordshire Regiment, only surviving child of John Benson Cooke, Principal Medical Officer, H.M. Convict Prison, Portland, to Mabel Sutton, only daughter of Sutton Hardwick Cooper, and of the late Mrs. Cooper.

Deaths.

BIRT.—On Sept. 19th, at Reading, Thomas Birt, Major, R.A.M.C., youngest son of the late Thomas Birt, M.D., of Leamington, aged 44 years.

MACDONALD.—On Sept. 20th, at 25 Carden Place, Aberdeen, James Macdonald, M.D., F.R.C.S.E., late H.M.I.S., in his 79th year.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIII. WEDNESDAY, OCTOBER 3, 1906. No. 14.

NOTES AND COMMENTS.

London Practitioners and the Hospital Sunday Fund.

The Metropolitan Counties' Branch of the British Medical Association has taken a step the importance of which is obviously great. On behalf of the Branch, which comprises 2,700 London practitioners, they have presented the Lord President of His Majesty's Privy Council with a memorandum on the Petition and Draft Charter of the Metropolitan Hospital Sunday Fund. While admitting the good work done by that body, they suggest a number of points for the consideration of the Privy Council in discussing the Sunday Fund's request for incorporation. The gist of their criticism is the failure of the Fund to control the field of action of the medical charities adequately, so as to secure full benefits to the poor on the one hand and to avoid injury to members of the medical profession on the other. In many ways this document is of supreme importance, most of all perhaps in the promise of future effective organisation within our ranks. The text of this important memorandum appears in full elsewhere in our present issue.

The Examination of Midwives in Ireland.

At a recent meeting of the heads of the various Dublin Maternity Hospitals, it was decided to send a deputation to the Chief Secretary for Ireland and to point out to him the urgent necessity that exists for the holding of examinations in Ireland by the Central Midwives Board, or by an Irish Board with similar functions. At the present time Irish trained nurses who desire to register themselves under the Midwives Act are compelled to proceed to London, or some other centre in England, in order to pass their examination, and this affects very injuriously a large number of nurses who cannot afford the time or the expense for such a step. In consequence, Irish trained nurses are placed in an apparently inferior position to their English sisters, a situation which cannot be tolerated for a moment in view of the high standard of the Irish training. Two different remedies for this state of affairs have been suggested, namely, either that the Central Midwives Board should hold examinations in Dublin, or that an amending act should be passed bringing Ireland into the original act and constituting an Irish Central Board. The Central Midwives Board has already said that it is impossible for it to adopt the first course, as Ireland is outside its jurisdiction. We are not admirers either of the policy or the capacity of the Board, but we confess that in this instance we consider it to be right, and that there is no precedent for a Board, created to exercise certain functions in England, extending their operations to a country which has been deliberately and definitely excluded. Moreover, it is possible that if the Board were so to extend its functions, any nurse already registered could apply for an injunction to restrain it from swelling the numbers of registered nurses by such a course.

The Reform of the Central Midwives Board.

It is apparent, then, that if the present anomalous position of the Irish trained nurse is to be rectified—and rectified it must be—an amending act must be passed. Such an act would readily solve the Irish question, but when this has been done a more difficult task remains to be discharged. In view of the reputation of the Central Midwives Board, it is inconceivable that an amending act can be passed which does not amend the present Board out of existence. In every way that unfortunate body has proved itself unsuited for the task which it has to discharge. It has shown that it possesses no sense of the dignity and importance of its position; it has shown that it can be actuated by questionable motives, and that even when its actions have been proved by demonstration to be unwise and improper, it has an extreme reluctance to reconsider them. Further, even supposing that the existing Board had acted since its creation in a broad, generous, and capable spirit, its constitution is such as to render it wholely unsuited for controlling the training and registration of midwives in England and Wales, not to speak of the added areas in Ireland and Scotland. By all means, then, let us have an amending act which will sweep away both the Irish grievance and the present Central Midwives Board, and which will substitute for the latter either a single body representative of all parts of the United Kingdom or a separate body for each of the three kingdoms. Above all, let the act constitute an authority which will be free from that which John Knox called "the monstrous regiment of women."

LEADING ARTICLES.

CAPE COLONY AND CANCER CURING.

A GREAT many of the difficulties that arise in the dealings of this country with her colonies occur through the colonies thinking their problems out for themselves, while the mother country has traditions which are binding on her, and which she thinks should be equally binding on her colonies. Often the accumulated experience represented by these traditions is of the highest value, and again not infrequently the prepossessions engendered by them are sad stumbling-blocks. But there is a freshness of thought in the colonies which places their domestic legislation far ahead of Great Britain, and in medical matters, as a rule, their laws relating to irregular practice and their administration are infinitely more comprehensive and logical than our own. It is almost impossible to think of a quack being so persistently prosecuted by the medical authorities in this country as to be unable to ply his trade, and of him petitioning Parliament for a relaxation of the law in his favour; and it is still more difficult to conceive of his petition being regarded so seriously as for a Select Committee to be formed purposely to examine his claims. Yet what more satisfactory way could Parliament take publicly to show not only the worthlessness of a particular quack's pretensions, but incidentally to shake the public belief in the whole system of quackery? This, however, is what has just happened in Cape Colony. There was a certain Mrs. Van Niekerk in the colony who had acquired a widespread reputation in South Africa as a curer of cancer, and to her people of all stations in life either came for treatment or sent for medicine. The breaches of the medical laws she committed were such that she frequently laid herself open to prosecution, and—this is the first important point—she was frequently prosecuted; indeed, so frequently that Mrs. Van Niekerk found her life not worth living, and, backed by powerful petitions from her patients, she appealed to the Cape Government to give her leave, in the public interest, to carry on her trade. So influential was the support she obtained that a Select Committee was chosen by Parliament to investigate her claims and report on them. A thorough inquiry was held, and, as the Committee contained some members obviously predisposed in her favour, there can be no question of the impartiality of the investigation. In the first place, an official analysis of the "remedies" by which the "cures" were effected was made. These consisted of a "cancer cure"—"Aesiab," as it was called—a "blood-purifying mixture," and a "healing ointment." "Aesiab" was found to be a caustic ointment, containing 45 per cent. of tartar emetic, 5 per cent. of chalk, and 50 per cent. of lard; the "blood-purifying mixture" had as its chief ingredient potassium iodide; and the "healing ointment" consisted almost entirely of common resin ointment. Next, the woman herself turned out to be an ignorant creature, as unable to explain her "system" as to answer ordinary questions intelligently, and quite without a vestige of medical training or knowledge. Every opportunity was given her of producing patients who had been cured by the treatment, and finally four were forthcoming. These people were medically examined and reported on, and it was clearly shown that there was no evidence whatever that they had, or ever had had, malignant disease. On the other hand, information of two undoubted cases of cancer which had been under Mrs. Van Niekerk's treatment, after being "given up" by doctors, was submitted to the Committee, and in both cases it was shown not only that the patients had died more rapidly than they would have done with due care, but also that their end had been accompanied with horrible suffering. Again, this woman, who advertised the fact that she worked as a philanthropist, was found to be charging the modest sum of £1 1s. 6d. for a pot of ointment worth 6d. or 1s. at the outside, according to current trade prices. The pots of this ointment were accompanied with directions containing grossly untrue statements, such as that "ultimate cure was sure and certain," and that it obviated the "dreadful knife of surgical operation"—a particularly cruel lie, because it caused sufferers to postpone their only chance of safety till too late. Thus the Committee reported, adding that where apparent cures had been wrought the patients were syphilitics whom the "blood-purifying mixture" had benefited by virtue of the potassium iodide it contained. The treatment of cancer by caustic ointments they showed to be an antiquated and all-but-useless treatment, and quite preposterous on account of its uncertainty and barbarity. In a word, the whole business was a vulgar fraud, conducted with ignorance, cruelty, and lying; and the Committee recommended that such changes should be made in the patent laws as to prevent even apparent Government sanction of such proceedings. Mrs. Van Niekerk's petition, it was resolved, should unhesitatingly be dismissed. For an impartial Parliamentary Committee to arrive at such conclusions, after a thorough and careful inquiry, shows what the claims of quacks amount to in the eyes of men of the world when the light of investigation is turned on to them, and we would that our legislators in the old country could take a lesson from their colonial brethren. Were a Royal Commission to investigate the subject of quackery, it could only find the grossest fraud and imposture in every corner of it.

TRUTH AND QUACKERY.

IN his issue of last week, the Editor of *Truth* has favoured THE MEDICAL PRESS AND CIRCULAR with several columns of more or less pertinent comment. The cause of this remarkable outburst is a letter that appeared in our columns a few weeks ago from a correspondent writing over the name of "Obscure Practitioner." As a matter of fact, the writer in question is a well-known and responsible medical man, whose communication was spontaneous. Needless to say, in publishing his letter we by no means undertook to endorse his views. For fairly obvious reasons, *Truth* has chosen to confuse the issues by assuming that the views of an "Obscure Practitioner" are those of the Editor of the MEDICAL PRESS AND CIRCULAR. In drawing editorial attention to that letter we

expressed an opinion in mild and temperate language that *Truth* considerably weakened his position as a castigator of frauds by admitting questionable advertisements to its own columns. On the occasion of a similar criticism some months since, *Truth* favoured this journal with a furious attack couched in rhetoric of the choicest Billingsgate type. The latter-day policy of that redoubtable journal makes one regret the time when, with Mr. Labouchere at the helm, facts and arguments were marshalled with precision and coherence. *Truth's* main sarcasm last week centred on the fact that although our correspondent called "Sanatogen" objectionable, an advertisement of that product appeared in the same number. Our editorial view of Sanatogen is that it is a valuable nutrient, advocated by medical men of high standing, and that our medical readers should be informed of its claims to attention. *Truth* may be reminded that even if an objectionable advertisement should by chance slip into our columns, our readers are medical men, that is to say, they are competent to form an opinion for themselves as to the credibility of statements therein published. Our censorship, moreover, is begotten of long and close experience of medical matters. On the other hand, an advertisement appearing, say, in *Truth*, reaches many persons who are absolutely unable to exercise any judgment of the slightest value as to the advertiser's statements. For instance, the "Ganesh Strap," a leather appliance "stuffed with fragrant herbs," guaranteed to cure wrinkles, and sold at a guinea and a guinea-and-a-half apiece, has for a long period been advertised in *Truth*. As a man of the world, the Editor of *Truth* has no doubt duly weighed and assessed the credibility of such a claim before admitting the advertisement to his columns, and before he pocketed large sums of money for introducing it to the notice of his readers. We confess to some curiosity to learn how the Editor of *Truth* can justify his continued advertisement of the strap and other remedies sold under similar mysterious names, which, we assume, like the stuffing, are also of Eastern origin. In future libel actions in which *Truth* is the defendant the point may probably engage the attention of counsel, in which case it cannot be avoided by several columns of persiflage and impertinence.

NOTES ON CURRENT TOPICS.

Coroner *versus* Medical Profession.

Although the attitude of Mr. Coroner Troutbeck with regard to medical men estranges our sympathy, it is impossible to avoid a certain admiration for his sustained courage. Alone among his judicial fellows he tilts fearlessly and unceasingly against a whole profession, and like his prototype, Don Quixote, is impervious to ridicule, reason, remonstrance, or reproof. With Dr. Freyberger as henchman, he defies the profession and continues to edify the public with tit-bits of more or less elementary scientific interest. Seeing that he has deprived the general practitioners of his district of the fees to which they are entitled both by right and by usage, it is hardly to be wondered at if the spirit of revolt has rooted itself deeply in Mr. Troutbeck's district. Last week a Lambeth medical man refused to grant a death certificate, and in consequence an inquest became necessary, when the usual "expert" Dr. Freyberger, made a *post-mortem* examination whereby double pneumonia was disclosed. The Coroner thereupon delivered a jeremiad in which he lamented the fact that he had no power to compel a doctor to give evidence. An alteration of the law was in his opinion urgently needed, so that a coroner might call for that information and pay for the report. Surely Mr. Troutbeck could have called the medical man and have paid him the usual guinea—a course that would probably have been far less costly to the ratepayers than the payment of a so-called "expert." However, this superior and courageous gentleman concluded, according to the newspaper reports, that "a machinery which had never been highly tested might have done for the condition of things 60 or 80 years ago, but it was not suitable in the present condition of medical knowledge and civilisation in England, and especially in London." It is not easy to understand, if a gentleman of Dr. Freyberger's stamp be essential to the safety of Londoners, why provincials should not be equally protected. On the other hand, we quite agree with Mr. Troutbeck that a change of coroner's law is urgently desirable, chiefly with a view to counteract his own high-handed innovations, involving, as they do, a gross injustice to general practitioners.

The Vivisection Commission.

The rather belated announcement of the names of the members of the Royal Commission on Vivisection had been so much discounted by the knowledge that this, that, and the other person had consented to serve, that the full composition of the Commission did not come with the shock of surprise. To the chairman, Lord Selby, no possible objection can be taken; indeed, from every point of view his appointment is an excellent one. The medical profession is strongly and satisfactorily represented, and the anti-vivisectionists have an able spokesman or two. We are not acquainted with the opinions held by all the lay members of the Commission, but we hope there is nothing in the anti-vivisectionists' objection that they should have had a larger proportionate representation. It is desirable that the report of this Commission not only shall be authoritative, but also that it shall be the result of searching inquiry from every point of view, and for this reason it might have been better if it had been possible to arrange for the anti-vivisectionists to have had people who satisfied them—that is, if it be possible ever to satisfy anti-vivisectionists. So certain are we not only of the value of experimental research on living animals, and of the humanity and conscientiousness of the research workers, that we welcome every legitimate method of investigation into the conduct both of

experiments and experimenters; and if there be any under-representation of the anti-vivisection interest, it may probably be due to the fact that no responsible person is acceptable to all anti-vivisectionists. Indeed, so divided are these good people that they have already begun to fall foul of each other, and we are edified by seeing, in the *Tribune* of September 25, Mr. Stephen Coleridge, the champion of the weak and oppressed, fire off his big guns at—Miss Kidd, the secretary of the weakling society which tries to compete with his own.

The "Little Brown Dog."

THE excitement which the newspapers tried to raise over the "little brown dog" incident has fizzled out rather badly. There was a transparent desire on their part that there should be a demonstration, a raid by medical students, or what not, to make good copy. We sincerely trust that nothing of the kind will take place; it would only draw attention to a piece of silly bravado on behalf of the Battersea Borough Council in accepting the monument, and in the recesses of Latchmere Park the brown dog and its followers are likely to sink into obscurity. The worst policy to adopt with regard to a matter of the kind is to advertise it. It is rumoured that the Council of University College are considering the propriety of bringing an action for libel against the responsible parties, and, while it would serve them right to be made to pay heavily for their folly, it is much to be hoped that the Council will not proceed to law unless they are advised not only as to ground for action, but that there is no reasonable doubt about a favourable verdict being obtained. The sickly sensationalism of the whole business is shown by the adoption of the adjective "little" to describe the brown dog. There is an appeal to the emotions in the word "little" which the word "big" would not make. The particular dog who was "done to death" was not little. The incident upon which the case of Bayliss *versus* Coleridge was founded is, one would suppose, one that anti-vivisectionists would have liked to draw a veil over. This revival of it lends itself to such obvious comments on the ideas of honour prevailing among them that we need say nothing further on the subject.

A Fiasco and a Vindication.

A HIGHLY satisfactory ending to the "Essex Burial Mystery" has come about. The facts which came out at the coroner's inquest on September 25 were that Dr. Adams, of Buckhurst Hill, attended an elderly lady, Mrs. Oliver, with whom he was on terms of friendship, for valvular disease of the heart. This lady's brother and his wife, who apparently had "expectations," found on her death that, like many expectations in this world, they were not crowned with fulfilment. These good people were also dissatisfied with Dr. Adams, and after Mrs. Oliver's death and burial they put the reasons for this dissatisfaction so strongly that it was decided the body should be exhumed and an inquest held. Accordingly this was done, and the result was a triumphant vindication of Dr. Adams. The brother's wife had told in her affidavit of dark doings in the sick-room; of continual sickness, pains in the head, the constant changing of the medicine, the difficulty of getting Dr. Adams to give her a definite answer. Consequently a complete analysis of the viscera was made by Dr. Willcox. No trace of poison of any kind was found, while, on the other hand, Dr. F. J. Simth, who made the *post-mortem*, found valvular disease of the heart and inflammation of the right lung. As this was the condition diagnosed by Dr. Adams during life, and confirmed by Dr. Rose Bradford, who saw Mrs. Oliver in consultation, the whole "mystery" was dispelled in a moment, and the jury gave a verdict handsomely exonerating Dr. Adams from any suspicion of unprofessional conduct. We sincerely congratulate him on his success after the anxiety he must have suffered during the long time of waiting. Had the findings been, as was possible, indeterminate, the unworthy cloud of suspicion might have remained and embittered his life. As it is, his honour as a gentleman and his skill as a physician are publicly established.

Mr. George R. Sims and "Ta'cho."

IT is announced that Mr. George R. Sims is surrendering his property in a much-advertised hair nostrum into the hands of a syndicate. This step will be regarded with approval by his many admirers in the medical profession. From the scientific point of view, it is absolutely futile to claim specific powers of stimulating a growth of hair by rubbing in drugs. It is, of course, a matter of common knowledge among medical men that in the form of patchy baldness, known as alopecia areata, the hair will often grow under the influence of strong stimulation, but just as often it grows of its own accord, or remains permanently bare. Now the fame of a hair restorer not infrequently depends on its effect in patchy baldness, whereas it is almost invariably useless against ordinary baldness of the crown, whether precocious or senile. The treatment of baldness, as a matter of fact, requires technical medical skill of the highest specialised type. Under these circumstances, medically unqualified persons claiming to cure hair troubles are likely to do more harm than good. Mr. George R. Sims has won name and fame as one of the most brilliant of modern journalists, and we are glad to learn he is abandoning his excursion into alien and less reputable territory. *Ne sutor ultra crepidam.*

Rontgen Rays and Cancer.

AMONG the many points connected with cancer that await the final professional verdict, is that of the therapeutic value of the Röntgen rays in the treatment of malignant neoplasms. The question has naturally occupied a prominent position at the International Congress for Cancer Research that took place last week at Frankfurt. The result of the discussions left matters much as they have been for several years past. It appears to have been pretty generally agreed that the rays were beneficial and sometimes curative in the case of superficial growths, but even there it was doubtful if permanent improvement resulted. Dr. Schiff,

of Vienna, observed that the cure of experimentally transplanted cancers in mice was encouraging. To have gained even a partial success in the treatment of so refractory a malady is a step in advance. No one who has seen the almost magical influence of the rays in abolishing pain and reducing bulk in secondary nodules recurring after operation can doubt that the Crookes' tube exercises some powerful, if ill-understood, influence over malignant growths. If on no other ground, the therapeutic value of the rays in abolishing pain is inestimable, and there is no other way of securing pure local analgesia by narcotic drugs.

Liniment Drinking.

One of the saddest features of the appalling waste of human life around us is the fact that so many deaths are, so to speak, uncalled for and needless. Clearly, it is the work of humane and progressive legislation to reduce to the lowest possible point the preventable margin placed in the hands of the great Devastator. Possibly some day, for instance, Parliament may find time to consider ways and means of checking the steady drain upon the resources of the nation involved in the accidental drinking of poison from medicine and other bottles. Only a week ago a Cardiff woman was given by her dearest friend a dose of deadly poison in the shape of an aconite and belladonna liniment taken from a physic phial placed on the mantel-shelf, alongside another containing a pepsine preparation. Some years ago we recorded the death of a workman who drank carbolic acid by error from a lemonade bottle, an incident that actually occurred within the four walls of a leading London hospital. The moral of it all is that many deaths would be prevented were Parliament to decree that all poisons should be sold and kept in distinctively-shaped bottles. We commend this useful bit of practical social legislation to the consideration of the present energetic Home Secretary, of Mr. John Burns, or of any private member to whom the claims of the community are above those of mere party.

Post Office and Pathological Research.

The revised regulations bearing on the carriage of pathological specimens by post, while giving greater liberties than those they supersede, are yet unduly restrictive. Under the late regulations it was compulsory that all such specimens should be sent by registered letter post; the necessity for registration is now abolished, but it is provided instead that the specimens are to be "enclosed in a receptacle hermetically sealed, which receptacle must itself be placed in a strong wooden leather, or metal case." It is not every medical practitioner who has at his hand the means of hermetically sealing a package, and in many cases delay completely frustrates the purpose of the proposed examination. Again, it is provided that "the packets must on no account be sent by parcel post." This is a needlessly irritating restriction, since its purpose is by no means plain, and it is impossible to send a specimen of considerable size by letter post. It is often necessary to transmit to a laboratory a tumour or other specimen of several pounds weight, and it will be impossible under the present regulations to make use of the post for this purpose. It is, of course, quite proper that the Postmaster-General should insist on sufficient precautions being taken as regards the packing and carriage of pathological specimens to prevent injury to the other packages committed to his charge, but there is no need that the precautions should be made prohibitive. Medical practitioners, like other subjects of His Majesty, are entitled to a reasonable use of postal facilities, and we see no justification for limiting that use by vexatious and unnecessary restrictions.

PERSONAL.

Sir Frederick Treves, Lord Rector of Aberdeen University, completed his duties on Saturday, and returned to London on Monday last.

Mr. Evan Spicer, chairman of the London County Council, opened a new wing of the Convalescent Home, Limpsfield, on September 29th.

Sir William Church, Sir William Collins, Mr. Gaskell, and Dr. George Wilson are the medical members of the Royal Commission on Vivisection.

Sir Francis Laking has practically recovered from his recent severe illness, and was able to leave Aberdeen on Monday last.

It is understood that the military hospital at Portsmouth will not be transferred to the new buildings on Portsdown Hill the Alexandra Hospital) until March. The last-named hospital is now approaching completion.

Mr. Alderman Thomas Boor Crosby, M.D., was last week admitted to the office of one of the sheriffs of the City of London for the ensuing year. Dr. Crosby, who is a graduate of the University of St. Andrews, has been in practice as a medical man for 54 years. He entered the Corporation as a Common Councilman for Langbourn Ward in 1877, and was unanimously elected alderman in 1898. He is a magistrate and lieutenant of the City of London, and a Past Master of the Turners' Company.

Harvard University has conferred the degree of LL.D. upon Sir Thomas Barlow and Professor Charles S. Sherrington.

It will relieve the minds of Coroners' jurors to learn that the Public Health Committee of the Camberwell Borough Council recommend that a glass partition should be placed between the bodies deposited at the mortuary and jurors whose unpleasant duty, especially in hot weather, it is to view them. Should this common-sense idea be adopted in all large towns the finer feelings of many, to whom the process is at all times objectionable, will be greatly relieved.

A CLINICAL LECTURE
ON
DISEASES AND INJURIES TO THE ORBIT.*

By SYDNEY STEPHENSON, M.B., F.R.C.S.

Ophthalmic Surgeon to the Evelina Hospital, the North-Eastern Hospital for Children, and the Queen Charlotte's Lying-in-Hospital.

PART II.

(2) Non-inflammatory affections of the orbit may be divided into three sub-classes, viz. :—(1) Where exophthalmos exists ; (2) where enophthalmos exists ; and (3) where exophthalmos alternates with enophthalmos.

Exophthalmos or proptosis(*a*) is the word applied to indicate protrusion of the eyeball. It may result from (*a*) increase in the size of the globe or of the orbital contents generally, or (*b*) diminution in the holding capacity of the orbit. The former is a much commoner cause than the latter. The last-named, however, is strikingly exemplified in that curious affection, leontiasis ossea, where the great increase in the thickness of the bones tends to extrude the eyeball from its socket, and, even better, in the malformation of the skull known as oxycephaly. Exophthalmos is an early, almost constant, and most valuable sign of orbital tumour. It may be so slight as to be difficult of recognition, or so marked as to be visible at a glance. Small degrees can be diagnosed only when one eye is affected. The higher grades lead to several serious consequences, of which the more important are eversion of the lids, epiphora, conjunctivitis, lagophthalmos, exposure keratitis, dislocation of the eyeball, and inflammation or atrophy of the optic disc from stretching of the optic nerve. Diplopia is common, and so is limitation of the ocular movements from mechanical interference with the optic nerve and extrinsic muscles of the eyeball. In order to recognise exophthalmos, we stand behind the patient (who should be seated), raise both upper lids, and compare the summits of the corneæ with one another, and with prominent landmarks, as the eyebrows. The position of the eyeballs in the orbit is generally such that a straight edge held vertically against the upper and lower margin of the orbit does not impinge upon either eye. Nevertheless, there are many individual variations in this respect. Special instruments, such as that of Ambialet (*Recueil d'Ophtalmologie*, June, 1903) have been devised for measuring the position of the eyeball. Hertel's exophthalmometer (*Arch. f. Ophthal.*, Bd. LX., 1, 1905) is perhaps the best instrument to use for the purpose. By means of an ingenious arrangement of mirrors and scales, the actual prominence of each eyeball can be read off in millimetres. A little practice, however, is needed before the appliance can be used to the best advantage.

It is well to remember that unilateral exophthalmos always suggests an orbital tumour, while bilateral exophthalmos generally means Parry's disease—that is, exophthalmic goitre.

Enophthalmos, a rare symptom, may be seen in acute disease, as cholera, in chronic disease, as myxœdema, after traumatism, in facial hemiatrophy, and, lastly, as one of the signs of paralysis of the cervical sympathetic nerve. The palpebral fissure is narrowed, and the eyeball appears to be unduly small—sunken, like an artificial eye, as it were. The physical cause of enophthalmos may be either (*a*) enlargement of the cavity of the orbit, or (*b*) diminution of the contents of the orbit.

I.—*Exophthalmos Exists.*—Under this head we have Parry's disease, pulsating exophthalmos, orbital tumours, and exophthalmos due to blood or to air in the orbit. In the first disease sooner or later both eyes are usually involved, but in the others one eye is alone affected.

Upon examination we find that the exophthalmos is bilateral, that the thyroid gland is enlarged, and that tachycardia is present. The disease is Parry's disease, or Graves', or Basedow's disease, or exophthalmic goitre, by all of which names it is known. The patient is likely to be a young or middle-aged anæmic woman, of highly-strung temperament. Fine tremors and sleeplessness may exist, and are important diagnostic points, especially in early cases. Look for five palpebral signs, any or all of which may be present :—(1) Pigmentation of the skin of the eyelids ; (2) a disturbance of the association normally existing between the movements of the upper lid and of the eyeball, in the sense that when the patient looks downwards, the lagging upper lid exposes more or less of the conjunctiva above the cornea (von Graefe's sign) ; (3) a retraction of the upper or (more rarely) of the lower lid, the effect of which is to give the patient a peculiar, staring appearance (Dalrymple's sign) ; (4) an infrequency in the act of involuntary winking, which, instead of taking place every few seconds, may occur once a minute or even seldomer (Stellwag's sign) ; (5) a fine tremor of the closed eyelids, inappreciable to the patient (Sansom's sign). I have observed in many patients suffering from this disease a concentric contraction of the visual field for small white objects, quite similar to the contraction met with in cases of amblyopia nervosa. H. Gifford (*Ophthalmic Record*, June, 1906) has recently described in cases of exophthalmic goitre an unusual difficulty in everting the upper eyelid, not due to exophthalmos. I have not yet been fortunate enough to meet with this sign, which is believed to be due to undue irritability of the levator of the eyelid.

We find that there is unilateral exophthalmos, and that pulsation is to be felt with the fingers, and murmurs heard when the stethoscope is placed over the closed eyelids. The disease is pulsating exophthalmos. There may be pain, and patients constantly complain of "noises in the head." Enlarged and pulsating vessels are sometimes present on the surface of the eyeball. Pulsation and murmurs and noises in the head cease on compressing the carotid artery, a most important diagnostic point. Chemosis may be present. Vision may suffer from papillitis ; the retinal veins are apt to be distended. The symptoms often closely follow a severe injury to the head. The common cause of the condition is a rupture of the internal carotid artery into the cavernous sinus, and this arteriovenous anastomosis is brought about either by traumatism or else by the rupture of an aneurism.

In addition to unilateral exophthalmos, we find on palpation with the finger a swelling between the margin of the orbit and the eyeball. An orbital tumour is almost certainly present.(*a*) The cardinal signs of this rare condition are three in number :—(1) Exophthalmos ; (2) limitation of movement of the eyeball ; and (3) the existence of a palpable tumour in some part of the orbit. Ptosis also is common in tumours originating from the upper part of the orbit. Disturbances of sight are frequent, and are due to papillitis, retinal hæmorrhages, and atrophy of the

*Delivered July 18th, 1906, in the Post-Graduate Course of Ophthalmology in the University of Oxford.

(*a*) By some the word "proptosis" is applied to mean protrusion of one eye, and "exophthalmos" protrusion of both eyes.

(*a*) Certain cases of more or less chronic periostitis may closely simulate tumour.

optic disc, following interference with the optic nerve and circulatory obstructions.

The commoner tumours of the orbit include dermoid cysts, exostosis, angiomata, and sarcomata. They must be distinguished from one another by the history of the case, the age of the patient, the rate of growth, the amount of pain, the interference with function, and by a consideration of the many points that have to be thought of in tumours originating from other parts of the body. Diagnosis, indeed, may be impossible until a piece of the growth has been submitted to microscopical examination. The tumour may be primary, secondary, or metastatic. To distinguish a secondary from a primary growth, consider the surgical possibilities, and examine, as far as possible, the frontal, ethmoidal, and sphenoidal sinuses and the maxillary antrum. Never omit to investigate the condition of the teeth, fauces, nasal cavities, and posterior choanæ in every suspected tumour of the orbit. Trans-illumination may be usefully employed. Malignant neoplasms, as a rule, grow rapidly, cause much pain, and speedily interfere with the movements of the globe. The converse, of course, is true of non-malignant growths.

Tumours of the optic nerve, although extremely rare, call for a few words of separate description. They generally occur in children, and present four main peculiarities:—(1) Papillitis is an early sign and may even foreshadow proptosis; (2) exophthalmos is in the axis of the orbit—that is to say, without lateral or vertical displacement; (3) the mobility of the eye tends to remain unimpaired for a long time; (4) an antero-posterior flattening of the globe may be caused by the pressure of the tumour, and this will reveal itself to ophthalmoscopic examination by increasing hypermetropia.

Dermoid cysts may be periorbital or orbital. The former are common. The periorbital dermoid, a congenital growth liable to increase in size after birth, has its seat of election at the outer end of the eyebrow, where on account of its superficial position it does not cause proptosis. It forms a firm, hemispherical movable mass, to which the skin is not attached. When such a tumour appears at the upper and inner angle of the orbit it must be carefully distinguished from meningocele or meningo-encephalocele. The differential diagnosis is given in the following table:—

Dermoid Cyst.	*Meningocele.*
1. A hard mass not reducible by pressure, and devoid of fluctuation or translucency.	1. A softer mass, the size of which can sometimes be reduced by pressure, with or without the production of cerebral symptoms. It may be translucent and fluctuate on pulsation.
2. No pulsation.	2. May pulsate synchronously with the brain.
3. No alteration when child cries.	3. May swell on crying.
4. No communication with cervical cavity.	4. A hole in the base may now and then be felt with the finger.

Exostosis may originate either from the frontal bone or break through into the orbit from the frontal sinus. They grow exceedingly slowly, but at length cause marked proptosis, with ulceration of the cornea and loss of sight. If within reach of the finger, their osseous characters are easily determined. Examination with the X-rays should not be omitted in these cases.

Mucocele or empyæma of the frontal sinus, when pronounced, is more likely to fall under the notice of the ophthalmic surgeon than of the rhinologist. It is due to closure of the duct leading from the sinus to the nose, generally as the result of traumatism In slight cases there will be pain and tenderness when pressure is made over the upper and inner part of the orbit, and pus or granulations may be recognised on examining the nose with the mirror and speculum. In marked cases, however, secretion will accumulate in the sinus, and, finally, appear as a tumour in the orbit by distending the osseous walls of the cavity. In such a case there is a tender swelling above the tendo oculi (or farther outwards), and the eyeball may be displaced forwards, downwards, and outwards. The wall of the tumour may "crackle" under the finger, or in advanced cases it may be felt to be perforated, with a fluctuating swelling protruding to the upper part of the orbit. It is well to recall the fact that the maxillary sinus is often simultaneously diseased, so that its condition should receive attention in these cases as a matter of routine.

Unilateral exophthalmos is sometimes set up as the result of blood or air in the tissues of the orbit. Blood may be extravasated in adults as the outcome of injuries, and in children as a symptom of scurvy, and in babies from injury at birth. For the recognition of the first and last forms the history will suffice. In good-class infants under twelve months of age, who have been reared on artificial foods or sterilised or condensed milk, it is not extremely uncommon for one eye to become suddenly proptosed, and for the second eye to suffer similarly a few days later. On careful examination, we can often find some indications of hæmorrhage about the ocular conjunctiva, the eyelids, or the face. Under such circumstances a further search will probably discover sponginess and ecchymosis of the gums (present only where teeth are erupted), and painful periosteal swellings of the femur or tibia. The disease is infantile scurvy, often though incorrectly called "scurvy-rickets."

Pass the finger over the swollen eyelids, and notice whether crepitation is to be felt. In this case emphysema exists. The lids are the seat of a "cold" or non-inflammatory œdema, and there is more or less proptosis. The condition generally follows a blow, and is due to the fact that the orbital tissues have been placed in communication with some of the adjacent air sinuses by fracture of the bones and rupture of the mucous membrane.

II.—*Enophthalmos Exists.*—If the enophthalmos follows a severe local injury it is due to (1) cicatricial contraction, or (2) fracture of the walls of the orbit. The history will suffice to distinguish these somewhat rare cases of traumatic enophthalmos.

If together with enophthalmos we find the pupil of the same eye contracted, especially in dull light, we suspect paralysis of the cervical sympathetic, and look for other signs of that condition in the shape of drooping of the upper lid, unilateral absence of perspiration, and a failure of the pupil to become larger when cocaine is dropped into the eye. Search for evidences of fracture of the clavicle, operations on the neck, or enlarged cervical or thyroid glands—that is to say, some of the commoner causes of the condition. Some cases date from birth, and appear to be due to injury with forceps, as in a case reported by Reese ("New York Eye and Ear Infirmary Reports," January, 1896), who observed in a baby delivered by forceps, marked cranial deformity, narrowing of the palpebral fissure, contraction of the pupil, and enophthalmos. A few years ago a child of five years was brought to me suffering from left-sided sympathetic paralysis ("Reports of the Society for the Study of Disease in Children," Vol. III., 1903, p. 149). A puckered scab was present about one inch above the outer third of the left clavicle, immediately behind the posterior belly of the sterno-mastoid muscle. On enquiry, it was found that eighteen days previously a retro-pharyngeal abscess had been evacuated. This case has its counterpart in an earlier one reported by Schapringer (*American Journal of Ophthalmology*, October, 1893).

Enophthalmos seems to be a constant sign of myxœdema, although it is often overlooked on account of the swelling of the face.

In facial hemiatrophy the enophthalmos is believed to be due to wasting of the orbital fat.

III.—*Exophthalmos Alternates with Enophthalmos.*—In so-called intermittent exophthalmos (of which some forty cases have now been reported) the eyeball protrudes when the patient stoops down, and occupies

its normal position, or is rather sunken, when he stands up. In some instances the exophthalmos may be induced by the patient simply holding his breath, as in a case lately reported by Posey (*Journ. American Med. Association*, February 18th, 1905). The eyelid may become painful and suffused and the retinal veins enlarged and pulsating when the stooping posture is maintained. Varicose veins may be visible around the orbit or elsewhere. It is significant that pressure upon the jugular veins leads to increased protrusion of the eyeball. There is often a history of injury. These cases of intermittent exophthalmos are believed to be due to the presence of varicose veins or some other kind of vascular neoplasm in the orbit. At the same time the condition must be distinguished from retro-ocular angiomata, where the protrusion of the eyeball is constant, while pulsation may be felt with the finger and a bruit heard with the stethoscope.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week's number will be by Sir Charles Ball, M.Ch., F.R.C.S., Honorary Surgeon to His Majesty the King in Ireland, Regius Professor of Surgery in the University of Dublin, Surgeon to Sir Patrick Dun's Hospital, on "The Operative Treatment of Internal Piles," with practical illustrations.*

ORIGINAL PAPERS.

THE ADULTERATION OF BUTTER

By E. W. HOPE, M.D.,
Medical Officer of Health for the City of Liverpool.

THE Sale of Food and Drugs Acts are very carefully administered in Liverpool, and the closest attention is given to the supervision of the food supply generally. There are eleven specially trained and qualified inspectors exclusively employed in these duties, and purchases under the Acts are frequently made by agents. The City Analyst, who is also an Analyst for the County, has his own laboratories for the City work. Butter is one of the most important articles of food, and owes its superiority to other fats to being more digestible, and consequently more nutritious. This explains its higher price. The amount consumed is very large, and assuming that Liverpool takes its proportion of the quantity consumed in the country in proportion to the population, it may be estimated that about 5,000 tons of butter are consumed annually in Liverpool. The value of it is about half a million sterling.

The quantity used, the ease with which adulteration can be practised, appear to have led to butter adulteration becoming a fine art, and it is a fact that certain adulterations of butter are exceedingly difficult of detection even by analysis, and it is practically impossible for the consumer to detect the fraud, owing to the ingenuity and skill of those engaged in adulterating.

The following table shows the number of samples of butter taken during each one of the last six years, together with the number of instances in which the butter was found to be adulterated :—

Year.	No. of samples of butter taken.	No. of convictions.	Amount of Penalties and Costs
			£ s. d.
1900	38	2	11 19 0
1901	94	11	28 7 0
1902	109	5	14 17 6
1903	174	17	103 1 6
1904	197	—	—
1905	254	8	23 16 6

It appears that convictions and penalties are followed by a withdrawal from the market of the adulterated articles, which are presumably sent elsewhere for a time. This result is probably due to the exposure as well as the penalty, but the offence recurs after a time. When a manufactured article is subject to extensive adulteration, the only method of effectually checking the adulteration is by supervision of the places of manufacture. It will be seen by the table that during the last five years the number of samples of butter taken for analysis in Liverpool has steadily increased, viz., from 94 in 1901, to 254 in 1905. It is quite true that the Health Committee of the City of Liverpool realises the importance of dealing with the subject, and will continue to deal with it in the interests of public health, regardless of cost; but, if cost is a consideration which a City of the size of Liverpool has to encounter, it is plain that smaller areas, with smaller funds at their disposal for the prevention of crime in regard to food adulterations, may be almost powerless.

From the standpoint of the public health administrator, the Sale of Food and Drugs Acts and the action taken under them, cannot be regarded as effectual in dealing with frauds similar to the adulteration of butter.

It may be taken for granted that the ingenuity of the adulterator is not only displayed in the methods of adulteration, but also in disposing of the adulterated articles. The procedure under the Act is costly, and may involve the purchase and analysis of many hundreds of samples before an adulterated one is found. Moreover, the vendor from whom the sample is purchased may be a perfectly innocent person. Having regard to the immense number of retail places, it is obvious that the supervision or detection of frauds at these points must be far more difficult than the supervision of the places of manufacture. A reference to the case of tea is up to a point permissible as an analogy. The examination of tea at the port of entry is a very much sounder way of protecting the public than leaving such protection to analysis of retail samples. Tea, it is true, is a non-perishable article, and a non-manufactured one, but excepting these features the analogy holds. There is even a closer analogy as regards water supply, the purity of which is primarily ensured by inspection at the source, and only very secondarily dealt with by testing at some few of the myriad points of domestic supply.

Butter, although a manufactured substance, has yet a definite natural composition, much, in fact, as milk has. The essential constituent of butter is fat, and whether it is water or salt or casein or fats other than butter that are added, they all of them are foreign to the essential constituent of butter. Unsalted butter should contain from 82 to 87 per cent. of fat, and 5 per cent. less in salted butter appears to be a fair proportion. The addition either of water, or of other fats to butter, even although they may in themselves be innocuous, are none the less fraudulent if the mixture is sold as butter, just as in the case of the addition of water to milk. The added substance in this case is not in itself harmful, but gross imposition and injury are inflicted when the mixture is sold as milk. It appears abundantly plain that with proper care and proper attention, butter need not contain more than 16 per cent. of water. The sale of butter containing a higher percentage of water should be dealt with in the same way that milk containing an excess of water is dealt with, but if the article is labelled and the purchaser duly informed, the sale would then be comparable with the sale of the mixture of coffee and chicory. The objection to milk-blended butter is not only that it contains more water, but that it decomposes more quickly, and consequently the use of antiseptics is more likely to be made.

All non-butter is margarine, and should be called margarine. The application of fancy names to adulterated or water-logged butter is highly objectionable on account of misleading the public. It must be borne in mind that vast numbers of purchasers are ignorant of all matters in connection with food supplies, and are most easily deceived by fancy

names. A remarkable instance of this within my own knowledge occurred in the case of an article sold in packets as "egg powders," made of carbonate of soda and tartrate of potash, or tartaric acid. The packets were labelled, "each packet contains the equivalent of one egg." In this case the poor woman who purchased them had actually been giving the powders to her children under the impression that it was a cheap way of giving eggs. This sufficiently illustrates the want of knowledge and thought on the part of the poorer classes.

Every place where butter is manufactured, blended, worked, treated by any process, stored, or made up for sale, should be licensed or registered, and open to inspection by the inspectors of some Government Department, such as the Board of Agriculture or the Local Government Board, and such regulations as may be found necessary should be made. It is of equally great importance that these places should be open to inspection by an officer of the local authority; this power of right of entry should extend beyond the district of the local authority, to factories, &c., in any district from which butter is sent in to the district of a local authority. There is a precedent for this in the case of tuberculous or contaminated milk. Imported pure butter is also admittedly "faked" in this country. The storing of articles simulating butter fat, capable of being used for the adulteration of butter, should be prohibited in butter factories.

The inspectors should have the power to inspect the processes, and also have power to take samples in the factory for the purpose of analysis.

Since the foregoing was written a Select Committee of the House of Commons have carefully considered the question of butter, and have tabulated their views. It would, however, be well if these suggestions were supplemented by power of entry and inspection being given to officers of local authorities as well as to those of Government Departments; moreover, it is also desirable that, in addition to the registration of premises where butter is blended, re-worked, or treated by any process, or where abnormal butter is habitually produced, places where butter is made or where butter is stored should also be registered. The necessity for this is too obvious to need comment. The recommendations of the Royal Commission are as follow:—

Recommendations.

1. That inspectors of the Board of Agriculture and Fisheries and the Department of Agriculture and Technical Instruction for Ireland should have power to enter any premises where they have reasonable grounds for believing that butter is made, blended, re-worked, treated by any process, adulterated, or stored.

2. That premises where butter is blended, or re-worked, or treated by any process, or where abnormal butter is habitually produced, shall be registered with the local authority of the district as a butter factory.

3. That no fat, other than butter fat, and no vegetable or other oils, nor any substance capable of being used as an adulterant of butter should be brought into or stored or allowed to be in any registered butter factory.

4. That no substance be added to butter whereby the percentage of moisture in the butter is increased.

5. That the addition to butter at any stage of the process of manufacture of any fat not derived from milk be expressly and directly prohibited.

6. That margarine, when sold by retail, should be handed to the purchaser in a wrapper, on which the word "Margarine" shall be printed in black, solid capital letters not less than ½-inch square, and if more than one wrapper is applied to the margarine, the word "Margarine" shall be printed as above on the inner wrapper; that no fancy name or description shall be permitted which refers to butter or anything connected with the dairy industry; that the outside wrapper, as well as the inside wrapper, should contain nothing but the word "Margarine" in type as aforesaid; and if any fancy name is printed on any other wrapper, the word "Margarine" should be suffixed or affixed to the fancy name in letters of the same size, colour, and type as those in which the fancy name is printed.

7. That no margarine made in any margarine factory shall, when the process of manufacture is complete, contain more than 16 per cent. of water, and no margarine shall be imported containing more than 16 per cent. of moisture.

8. That premises where margarine is re-worked or submitted to any process shall be registered as margarine factories.

9. That Sub-section 3 of Section 20 of the Sale of Food and Drugs Act, 1899, be amended so as to provide that a warranty or invoice given by a person resident outside the United Kingdom shall not be available as a defence to any proceedings under the Sale of Food and Drugs Acts.

10. That penalties for the importation of adulterated butter should be proportionate to the magnitude of the consignment.

11. That all practicable steps should be taken to bring about international agreements as to the prevention of adulteration.

12. That Section 4 of the Sale of Food and Drugs Act, 1899, should be amended so as to give the Board of Agriculture and Fisheries, and the Department of Agriculture and Technical Instruction for Ireland power to fix standards for curd, and to give the Local Government Board power to fix standards for preservatives.

13. That the Department of Agriculture and Technical Instruction for Ireland should have power to take proceedings under the Merchandise Marks Act.

14. That nothing shall be sold under the name of butter which contains more than 16 per cent. of moisture.

15. That substances other than butter (not being margarine) containing butter fat should be sold, with a limit of 24 per cent. of moisture, under a name approved by the Board of Agriculture and Fisheries; provided that such name should not be calculated to prejudice the sale of the article.

16. That such substances when sold by retail should be delivered to the purchaser in a wrapper, approved by the Board of Agriculture and Fisheries, containing a description of the nature, substance, and quality of the article; and as far as possible under the same conditions as apply to the sale of margarine.

17. That the provisions of the Margarine Act of 1887 as amended by the Sale of Food and Drugs Act, 1899, should apply to all such substances.

18. Inspectors acting under the special direction of the local authority should have power to enter butter factories, to inspect any process, and to take samples.

19. That butter having been treated by any process shall not be allowed to be replaced in the original packages.

A CASE OF ANKYLOSTOMIASIS (a)

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Ankylostomiasis, speaking broadly, is a disease of tropical and sub-tropical countries. But in this country our interest in it was greatly increased a few years back by the discovery that an epidemic of anæmia which occurred amongst Cornish miners was really the manifestation of Ankylostomiasis—the infection having been introduced into the mines by workmen who had returned infected from some Continental mining district.

Still more recently—within the last few weeks—our interest in the disease has been further

(a) Read before the Liverpool Medical Institution.

enhanced by the fact that it is expressly mentioned by name in the Workmen's Compensation Bill, now before Parliament, as a disease, the contraction of which by a workman in the course of his work renders his employer liable to the payment of compensation.

As, therefore, it is conceivable that questions as to this disease may arise in actions at law, in which we as medical men may be involved, it seemed to me not inappropriate that I should report an interesting case of this complaint which a few months ago was under my care in the Tropical Ward of the Royal Southern Hospital.

The case was interesting because the patient was a native of Liverpool, a seafaring man.

Now, considering the very extensive prevalence of ankylostomiasis in tropical countries, and the fact that British sailors and soldiers are to be found in all parts of the world, it is at first sight somewhat astonishing that the disease is not much more frequently introduced into England by these classes of men. But it, as a matter of fact, is not very surprising, as it is found by experience that infection is generally due to absolute neglect of all rules of cleanliness and decency, and that a very moderate amount of care is sufficient to guard against the disease. As confirmation of this, I may mention that in Egypt, where ankylostomiasis is most widely distributed, it is almost, if not quite, unknown amongst the English troops.

It has, however, long been known that infected persons returning home from infected districts do bring the parasites with them. In this country this, fortunately, is not a cause of much alarm, except in the case of miners. The disease has not yet been found to spread readily above Lat. 47N. (which crosses the middle of France) except in the stimulating warmth of mines, and even in them only as far North as Latitude 52°, which includes the lower fourth of England, Holland, Belgium, and Germany.

Nature of Disease.—Ankylostomiasis is a disease characterised by certain intestinal and nervous symptoms, and a gradually progressive anæmia, which may reach any degree of severity from a slight pallor to a condition of blood which in prolonged cases is irremediable and fatal.

It is caused by the introduction into the intestinal canal of the larvæ of the ankylostomum duodenale which thereupon are enabled to develop into their adult condition, and to remain as permanent parasites on their human host.

These worms are nematoid in type, and to the naked eye are not unlike the common threadworm in appearance. If these worms were present singly or in small numbers, the amount of damage would be slight, but unfortunately when infection takes place it is found that scores of larvæ are generally introduced at the same time, the result being that they may give rise to symptoms of the utmost gravity. I say *may* because it is by no means uncommon to find at autopsies in the tropics that the intestines had harboured these parasites without there having been any obvious constitutional symptoms during life.

I pass round a tube containing a bunch of adult worms which look as though they might be short bristles from a common paint-brush. During life these worms are a pale, reddish colour, but as you see them after their death they are greyish white. There is not the same disparity in size between the sexes that is usually found in parasites, the female being as usual the larger—about 12 mm long—but only exceeding the average male by about 2 mm. In both the head end is tapering, and has a circular opening leading into a concave space armed with four hard curved teeth. The concavity of the space enables the parasite to attach itself by suction to the mucous membrane of the intestine, and its hold is further strengthened by its four curved teeth. The worms are mostly found after death in the jejunum, notwithstanding their name. After attaching themselves to the mucous membrane they proceed to suck a fold of it into their mouth cavity, and this fold is gradually digested and utilised as the parasite's sustenance. It used to be thought that the creatures lived by sucking the blood of the host, and this was supposed to be the cause of the ensuing anæmia; but in all probability what the worm aims at is not blood, but an unending meal off mucous membrane. Occasionally it is true that a small artery may be opened into, and in that case blood is lost both into the cavity of the worm's body and into the host's intestine. On these occasions and at the times when the animal has digested all the membrane within its reach, and shifts to new pastures, some oozing takes place, and there is actual loss of blood to the host. These occurrences, however, are not frequent.

The method of digestion is assumed to be as follows:—

The worm is possessed of three large glands, the ducts of which open just at the root of the teeth, and it is reasonably conjectured that the secretion of one or more of these glands is injected into the fold of mucous membrane in the parasite's mouth in order to lead to its digestion and assimilation.

In all probability some of the secretion of these glands gets, at the same time, into the circulation of the host, and acting as a hæmolytic poison induces those blood changes which in their turn explain the symptoms of ankylostomiasis.

The reasons for assuming that the anæmia is induced in this way, rather than by direct loss of blood, are, firstly, that the quantity of altered blood discharged by the rectum is small out of all proportion to the anæmia; and secondly, that the anæmia is not of the hæmorrhagic, but of the chlorotic type.

The female worms, after fixing themselves, soon begin to excrete eggs in enormous numbers, and it is the discovery of the eggs in the fæces which confirms the diagnosis of ankylostomiasis. Their discovery is very easy; all that is necessary being to place a speck of the fæces, diluted if necessary with a drop of water, on a slide, to cover it with a cover-glass, and to examine it with the low objective of the microscope. The ova are large, and easily recognised. They are clear and transparent at the periphery, whereas nearly all other intestinal ova are dark and bile-stained. They are oval in shape, measuring on an average about 60 μ by 40 μ. They have a delicate transparent shell, through which two or four, or more, yolk-segments can be easily seen when the eggs are passed out of the bowel.

The ova develop quickly after excretion. If the fæces be kept in a warm room for 24 or 48 hours, and then examined, many of the ova will be seen filled by coiled-up embryos. The latter go through several stages of development during the first week, but after that pass into a dormant

condition, in which they may remain alive for many weeks or months in damp earth. If during this period they are by any means, such as unwashed vegetables, or the muddy hands of the miner or agriculturist, or the food of the geophagist introduced into the human body, they find their way again into the intestine, develop into the adult form of the worm, and commence the cycle over again.

Till latterly this method of infection (by means of food) was supposed to be the only one. It is probably the most common method, but within the last few years Professor Loos, first by accident and afterwards by experiment, demonstrated another possible mode of infection. He proved that the larvæ, if brought in water into contact with the human skin, have the power of penetrating through it, and of reaching by a marvellously ingenious route their ultimate goal in the duodenum and jejunum.

It has been shown by experiments that the larvæ reach the cutis vera through the hair follicles, and then penetrate into either a capillary or a lymph-vessel. Carried by the stream in either of these vessels, they ultimately reach the right side of the heart and later the pulmonary capillaries. Here they leave the blood vessels and bore their way into the air cells, from which they travel upwards through the bronchial capillaries, the bronchi, the trachea, and larynx till they reach the pharynx, from which their passage into the stomach is simple.

It is possible that in my patient the larvæ found an entry into his system in this manner. One evening while trying to return to his ship at Pernambuco, very intoxicated, he dropped to the ground, and lay all night on his right side on the wet, earthy sand. The next day his body and the outer part of the thigh on the right side were red and inflamed, and dotted with innumerable red spots which were very itchy and smarting. This is similar to the result which follows when larvæ are experimentally placed upon the skin.

Some days later he was seized while at work with sudden giddiness and diarrhœa. The latter continued off and on till admission, accompanied by abdominal and epigastric pain. He described the stools as having been liquid, jet black in colour, and at times slimy. With reference to this history it may be remarked that giddiness and epigastric pain or discomfort are very common early symptoms of ankylostomiasis. Diarrhœa, however, is not usually present, and the passage of tarry stools is very rare. If in this instance they are to be ascribed to the infection, it suggests that the number of larvæ which had penetrated the patient's system was unusually large, and produced considerable intestinal congestion and irritation.

The patient was admitted into hospital, complaining of diarrhœa, on May 22nd of last year. He was debilitated, very anæmic in appearance, and had a dull, heavy facial aspect. It is interesting to note that this combination of debility, anæmia, and stupidity of expression is frequently found in patients suffering from ankylostomiasis.

His appetite was unusually good, and had been throughout his illness—another characteristic of the subjects of this disease, in all but the very latest stages.

Two days after admission he informed us that he had passed per rectum a small worm which he described as white, thin, slightly twisted, and about one-eighth of an inch long; and also said that he had passed two similar worms during the fortnight prior to entering the hospital. Threadworms and ankylostomes are somewhat similar in appearance, but as it is extremely rare for the latter to travel down to the anus I concluded that he was suffering from threadworms. I accordingly ordered him a dose of santonin, which, however, did not lead to the expulsion of any worms.

As the diarrhœa persisted in spite of treatment, on June 1st the fæces were examined microscopically, and were found to contain numerous ankylostome eggs. This discovery settled the diagnosis and was a sufficient explanation of the patient's various symptoms.

During the following ten days the patient suffered much pain from the development of an ischio-rectal abscess, which was incised with much relief to him on June 10th. This is not a recognised complication of ankylostomiasis, because the worms are rarely found in the rectum, and it is open to question whether in this case it can be ascribed to the irritation caused by the worms, but their unusual presence in the rectum of this patient makes such a suggestion feasible. The suppuration and pain considerably lowered the patient's strength and increased his anæmia.

During the development of the abscess after consultation with Professor Ross, it was not deemed desirable to commence the specific treatment of the disease by anthelminthics on account of their depressing properties.

With regard to treatment, Dr. Sandwith, who has had enormous experience of ankylostomiasis in Egypt, after prolonged trial of male fern, B. naphthol, and other anthelminthics which at various times have been vaunted as the best remedy for the ankylostomes, has expressed the opinion that it is waste of time to try any other anthelminthic than thymol, which appears to be a specific against the worms. But to be effective very large doses—enormously larger than the pharmacopœal maximum of 2 grains—must be employed. And the use of such large doses requires special precautions to be taken. In some persons the drug produces somewhat dangerous collapse and the effect of the first dose should be carefully observed. Fortunately it is very insoluble in the human stomach, and it is this insolubility which renders it safe to administer such large doses, while leaving the drug free to exert its topical effect on the parasites. It must be remembered in this connection that thymol is soluble in alcohol, ether, chloroform, and oils, and that therefore none of these must be given to the patient either shortly before or after the drug. Serious accidents have happened through neglect of this precaution. If patients show any signs of collapse after their first dose of thymol, they must be stimulated *not* by alcohol, but by strychnine subcutaneously, or hot coffee per rectum. The contra-indications to the use of thymol in Dr. Sandwith's opinion are excessive debility, age above 60, very low temperature, and advanced disease of heart or any other organ. It is necessary that the patient should be kept in bed for some hours after taking the medicine, and that a full dose of sulphate of magnesia or castor oil should be given two hours after the thymol, in order to drive it out of the bowels as soon as it has served its purpose.

There are several ways in which the drug may be administered.

1.—Keep the patient in bed for a day or two on low diet, and let the bowels be cleared out by an aperient. In the morning give three or four doses of 15–25 grains of thymol at intervals of one hour, and follow them with a purge. In some cases one such course is sufficient to expel all the ankylostomes, but if ova continue to appear, one or more subsequent courses may be given at intervals of six or seven days.

2.—Keep the patient in bed all one day on milk diet, and without a preceding aperient give 15 grains of thymol in the evening. Repeat the same dose early the following morning, give an ounce of sulphate of magnesia two hours later, and keep the patient in bed the second day. Three or four such courses are the average number required for cure.

3.—Give a daily morning dose of 15 to 20 grains of thymol, followed by an aperient, till ova cease to appear.

As soon as the condition of my patient permitted, I commenced with the thymol treatment, and to gauge his power of taking it, I gave 10½ grains on the mornings of June 15th and 17th. Finding that it was well borne I gave him on the morning of the 20th four hourly doses of 15 grains. But the result was unsatisfactory, and the ova continued as numerous as before.

The course was repeated a few days later, but again without success as on the 27th the ova were still very numerous, and apparently not diminished in numbers.

The general condition of the patient was gradually getting worse, and by this time examination of the blood showed that the number of red corpuscles was reduced to 1,644,000 per c.m., and he complained more and more of palpitation and dyspnœa, which became alarmingly severe. The number of leucocytes, as is usual in this disease, was slightly increased, being 13,100 per c.m.; and a differential count showed that the proportion of eosinophiles was as high as 47 per cent. Eosinophilia is characteristic of the disease, but is not of much value in diagnosis, as it occurs in infections due to many other parasites. Its continuance, however, in a case of uncomplicated ankylostomiasis during treatment is of importance in that it indicates that the patient is still harbouring some of the worms.

The urgency of the patient's condition demanded that a fresh attempt should be made to destroy the parasites which seemed so resistant to treatment. Rather than try another anthelminthic we determined to administer the thymol according to the third manner described above. Twenty grains were given each morning, and after five days there seemed a slight diminution in the number of ova in the fæces. As the patient was bearing the drug well, the daily dose was increased to 30 grains. One week later the ova were few in number, and in still another week had quite ceased to be excreted.

During this time, with the help of an iron mixture the patient rapidly improved, the anæmia disappearing and his strength returning.

He was kept under observation for nine days longer, but no more ova were found in the fæces, and he was discharged feeling well and strong.

[Since this paper was read the patient presented himself again after an interval of nine months at the hospital, complaining of debility and palpitation. He had felt quite well for about eight months, spending the time partly at sea, and partly on shore as a dock labourer. During the ninth month he had not felt well, and he was getting weaker. He was also somewhat anæmic. Fearing that he was suffering from a recurrence of the disease I admitted him into the ward, and found upon examination of the fæces that such was the case. The ova were much fewer in number than on the first occasion, but it was clear that he had not completely got rid of his parasites. It was evident that the fact that no ova had been seen, even after fairly careful observation, for nine days was not sufficient to prove that the patient was cured.

On this second occasion I administered the thymol according to the second method described in the paper, which is the routine method at the Kasr-el-Ainy Hospital. But although the patient had several courses the ova did not cease to be excreted. I accordingly returned to the method of daily morning dose, and after some time the fæces were again found to be free from eggs. I kept him under observation till the fæces had been free for over a fortnight, and he was then discharged apparently cured.

This recurrence, however, shows the necessity of great caution in pronouncing a patient cured.]

CEREBRO-SPINAL MENINGITIS. (a)

BY PROF. JUDICE CABRAL, M.D.,
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[SPECIALLY REPORTED FOR THIS JOURNAL.]

EPIDEMIC cerebro-spinal meningitis is now generally recognised and described as an infectious disease due to the presence of the *diplococcus intracellularis* discovered by Weichselbaum. Other organisms, it is true, may give rise to inflammation of the cerebro-spinal meninges, but not to epidemic meningitis, properly so-called.

The precise mode of invasion of the organism is still enveloped in obscurity, and we are reduced to more or less plausible conjectures. Some observers believe that the organism enters *via* the respiratory tract, while others hold that the alimentary tract provides the open door, digestive disturbances, which, it must be admitted, often precede meningitis, being a predisposing cause. The most generally received opinion is in favour of the organism finding its way into the body through the nasal mucosa, the meningococcus entering the cranium through the cribriform process of the ethmoid along the lymphatic vessels of the pituitary membrane.

Dr. Westenhoffer not long since suggested that the germs were propagated by the nutrient vessels that traverse the sphenoid, admitting, nevertheless, that the organism may start from the middle ear along the carotico-tympanic canaliculi. This observer, however, holds that the meningococcus never takes the ethmoid route.

The contagiousness of epidemic cerebro-spinal meningitis is one of the most debated points in the etiology of this disease, and the pathologists who refuse to admit it are more numerous than those who accept this view. Personally, basing our conclusion on facts observed in the course of the epidemic at Algarva, we hold that every individual suffering from meningitis consti-

(a) Abstract of Paper read before the Fifteenth International Congress of Medicine, held at Lisbon, April, 1906.

tutes a focus of infection, whether the propagation takes place by direct contact or by the intermediary of contaminated linen, etc.

In the majority of cases the attack of meningitis sets in suddenly, the subject having previously been in excellent health. The symptoms which form the classical tripod of the onset are shivering, headache, and vomiting. In certain exceptional cases prodromal symptoms have been observed, such, for instance, as general prostration, with tingling or pain in the lower limbs, intestinal colic or gastro-enteritis. It is especially in cases where the meningitis is principally spinal that we get the gradual onset with motor and sensory disturbances.

The sudden onset is almost always followed by a short period of remission, during which the initial symptoms subside, or give place to torpor. This period, which lasts a few hours, occurs on the second day, or, it may be, on the evening of the first day. Soon the vomiting ceases, but the temperature is more or less raised. Symptoms of motor and sensory stimulation make their appearance: convulsions, contractures, opisthotonos, delirium, restlessness, and insomnia dominate the clinical picture. There is obstinate constipation, and the tongue is dry and sticky. Anorexia and thirst complete the list of digestive disturbances. This state lasts for a week or so, gradually subsiding in mild cases, or the symptoms may suddenly disappear altogether from one day to another.

Death occurs in 40 per cent. of the cases and the immediate cause of death varies according to the particular form of the disease. In hyperacute cases, in which the disease runs its course in a few hours, and in which the organism is, so to speak, overwhelmed by the violence of the attack, death takes place in coma. In the convulsive forms death is due to asphyxia, caused by tetanisation of the diaphragm and immobilisation of the thorax. Not infrequently, however, nutritive perversions of the nerve centres, determined by the meningeal inflammation, bring about the bulbar syndroma in which death supervenes. In some cases enfeeblement of the myocardium, with pulmonary congestion and œdema, constitutes the terminal accidents. In other cases death is precipitated by œdema of the glottis. Myocarditis, general asthenia, collapse, coma, bed sores, and inanition are the causes of death in the chronic cases.

In spite of its diversity of forms and symptoms, the diagnosis of epidemic cerebro-spinal meningitis is usually fairly easy. The acute onset and the uniformity of the phenomena by which this onset is ushered in (headache, vomiting, and rigors), the prompt supervention of spinal pain, of rigidity of the neck, of opisthotonos, the appearance of labial herpes and Kernig's sign, only to mention the commoner symptoms, prevent our mistaking it for any other disease, especially when meningitis is epidemic at the time.

In sporadic cases, however, the diagnosis may present considerable difficulty. It is especially with typhoid fever that confusion is likely to arise, either because the typhoid fever, especially in its ataxic form, is associated with grave symptoms involving the nerve centres, or because the meningitis, departing from its usual form, by its onset, by the temperature curves, by the presence of gastro-intestinal complications, and by its general course, may present appearances not at all unlike that of enteric fever. We must seek the differential diagnosis in sero-reaction on the one hand and in lumber puncture on the other.

Another affection with which the disease has often been confounded is miliary tuberculosis. Here again the bacteriological and cytological examination of the cerebro-spinal fluid should put us on the right track.

The diagnosis between epidemic cerebro-spinal and other forms of meningitis, especially tuberculous meningitis, often presents grave difficulty. Certain it is that in most instances tuberculous meningitis is preceded by prodromata, while in epidemic cerebro-spinal meningitis the onset is, as a rule, very sudden. There are exceptions to this rule, for tuberculous meningitis has been known to supervene suddenly, and epidemic cerebro-spinal meningitis may, in rare instances, be preceded by prodromal signs.

There are still two important factors to be considered in arriving at the diagnosis—viz.: the cytological examination of the cerebro-spinal fluid and cultures of this fluid in gelose-blood. Cytological examination of the figured elements obtained by centrifugation of the fluid enables us to recognise the presence of an excess of polynuclear leucocytes in cases of acute meningitis, meningococcal or otherwise, as well as the predominance of lymphocytes in tuberculous meningitis. Attention must however be called to a possible source of error when the fluid has been withdrawn during a period of remission, for in such event the lymphocytes predominate over the other forms.

The prognosis in epidemic cerebro-spinal meningitis is always grave, although the gravity varies from one epidemic to another, and even in the same epidemic. Our statistics for 1901, with 151 cases, give a mortality of 41.30 per cent. In 1902 the epidemic, which was beginning to decline, gave us only 26 cases, but the mortality was much greater than the previous year, viz., 57.6 per cent.

The gravity of the attack is dependent upon the severity of the inaugural nervous symptoms, to the violence and duration of the delirium and convulsions, and to the degree of fever.

In the matter of treatment various antispasmodics and narcotics have been tried, along with derivatives and counter-irritants, alterative and antipyretic drugs and nerve sedatives, invariably with absolutely negative results from a curative point of view, and very mediocre results even as palliatives.

We have never seen any beneficial results follow the use of hot baths, the questionable efficacy of the baths not compensating by any means the extreme suffering to which they give rise, in view of the extraordinarily hyperæsthetic state of the patient. Local blood-letting, when resorted to at the onset in the form of leeches over the mastoid process, and wet cupping along the spinal column, has been followed by a very pronounced amelioration and sound refreshing sleep for some hours. Counter-irritants over the dorsal region, repeated at intervals of several days, appear to be of some service. With regard to internal medication, calomel, opium and the bromides are the only drugs that yield any tangible result. Our experience leads us to regard the administration of copious enemata (a quart) of boiled water, plain or mixed with substances exerting a slightly purgative action, as beneficial in nearly all cases.

A telegram to the *Matin* from Lyons confirms the existence of leprosy in the Swiss village of Guitet. Suspected cases are also reported from Feigel, in the neighbourhood of Guitet. A young man in an advanced stage of the disease died on the 15th ult.

THE OUT-PATIENTS' ROOM.

GREAT NORTHERN HOSPITAL.

Injury to Pelvis.

BY PEYTON BEALE, F.R.C.S.

MR. BEALE was asked to see, on behalf of his colleague Mr. Mower White, a boy, æt. about 5, who had been run over by a dray and brought to the surgery a few minutes previously. It appeared that the wheel of the dray had passed obliquely across the lower part of the abdomen, but beyond this no evidence as to the accident was obtainable. The patient was suffering intensely from shock, and on placing the hand over the region of the symphysis pubis, the latter could not be felt at all. There was rather copious hæmorrhage from the rectum, and so it was deemed advisable to examine under an anæsthetic. When the boy was under chloroform the rectum was examined, and a very large rent was found in its anterior wall; the finger passed through this, and could be felt beneath the abdominal wall, but no trace of the symphysis pubis could be found. As the whole of the space between the rectum and the anterior abdominal wall was full of fæcal matter, an incision was made between the recti and over the region where the symphysis pubis should have been. This incision exposed a large cavity full of blood-clot and fæces, and on further exploration it was seen that the two pubic bones had been separated at the symphysis, and that they were four inches apart. A rubber catheter was passed into the bladder without difficulty, and it was at once evident that both the whole length of the urethra and the bladder had entirely escaped injury. The pelvis was examined carefully, but no fracture could be found on either side, though the sacro-iliac joints were somewhat movable. It therefore seemed clear that the wheel had passed from above downwards over the abdomen, and had split the symphysis pubis. Mr. Beale could only assume that the boy's rectum had been quite full of fæces, and that its anterior wall had ruptured under the pressure of the wheel. The two pubic bones were brought together and sutured with silver wire, the cavity of the pelvis was thoroughly washed out with hot lotion, so as to clear away all the blood and fæces, and large gauze drains were inserted in the rectum and in the abdominal incision. The patient was at once taken into the ward. Mr. Beale said that the most difficult point to explain was the rupture of the anterior wall of the rectum. He had seen some cases of fractured pelvis in which the descending ramus of the pubis had been broken and forced downwards into the rectum, its jagged end being felt on a rectal examination being made; but in the present case the rent was a very large one—at least three inches long—and there was apparently no fracture of either ramus of the pubis or of the ischium. He had never before seen any case like it, nor could he realise how a wheel passing over the pelvis could inflict such an injury. At the same time, he could not realise how such conditions could be found and at the same time how the urethra and bladder could have escaped injury. In the second place, he could not realise had mostly been caused by the patient being crushed by the tailboard of a cart pinning him against a wall. Some were caused by the patient being run over, and one, the most serious he had seen, and which he had reported some years ago, was caused by the passage of one of the hind wheels of a steam-roller over a man's pelvis.

OPERATING THEATRES.

EALING COTTAGE HOSPITAL.

ABDOMINAL PREGNANCY.—MR. PEYTON BEALE (in Mr. Carless' absence), operated on a woman æt. about 30, who had been admitted with intense abdominal pain and high temperature. Nothing characteristic could be made out about the onset of the symptoms. She noticed the pain in the abdomen some two days previously about the region of the umbilicus, and it had gradually become more severe up to the time of admission. There was no distension of the abdomen, but it was intensely tender all over on deep pressure. There was a little fluid in both flanks. Urine was passed normally. The bowels had been opened freely. The uterus on examination was larger than normal, and slightly fixed. An incision was made in the middle line of the abdomen below the umbilicus. It was at once evident that there was diffuse general peritonitis, and on investigation this was found to be most acute in the region of the fundus of the uterus. Here the small intestines were coated with thick yellow lymph, various coils being adherent to one another. The appendix, ovaries, and Fallopian tubes were all normal, but attached to the left side of the uterus was a spherical soft tumour about three inches in diameter, and it was quite obvious that from this the general peritonitis had emanated. This tumour was gradually brought into view at the abdominal incision, and it was then seen that blood-stained serous fluid was escaping through a small opening in it. During the attempt to get a clear view of it, it broke away from the uterus, and was easily removed with the hand. It was then found to be a cyst-like structure, containing some blood-clot, and it was evidently an abdominal gestation, probably of about a month's duration; its contents had an unpleasant odour, but this was not fæcal. The difficulty was to account for the general peritonitis; but the assumption was that the infection spread from the cyst, as this was obviously the region where the peritonitis was most intense. As much of the lymph as possible was peeled off the intestine, and the abdominal cavity rapidly washed out with hot sterile salt solution. The abdominal wound was closed, a gauze drain being left at its lower end. Mr. Beale said that he assumed that this was primarily a tubal gestation which had passed into the abdominal cavity. He had not previously seen a case of this kind, although he had operated upon many ruptured tubal gestations; in the latter cases there was practically no general peritonitis, and they all occurred at a later stage of pregnancy, so that the chief symptoms were a large amount of blood free in the abdominal cavity, the patient suffering from collapse as the result of the hæmorrhage. In the present case he did not think the cyst had ruptured through any visible aperture before he had handled it, and noting the absence of any marked inflammation about the openings of either of the Fallopian tubes he was at a loss to account for the very acute peritonitis which was present.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Sept. 30th, 1906.

A NEW DIPLOMA.

A new diploma has been instituted in France, styled Certificate of Superior Medical Studies, and takes a place between the usual M.D. and the Fellowship. Only those possessing the M.D. are admitted to the examination, which is written and oral.

The written portion comprises a composition in anatomy, histology, and pathology, while the oral embraces general pathology. If the candidate has

passed these preliminaries, he undergoes an examination in practical pathological anatomy, comprising the different methods of exploring the tissues and morbid tumours.

The jury is composed of nine members taken from the professors of medical faculties. The examinations will be held twice a year, the first to take place in October of next year.

The new diploma will be required of all assistant professors in the Universities.

A Sign of Arterio-Sclerosis.

Attention has been drawn to a sign of arterio-sclerosis which seems to dispel all doubt on the affection. It is called the palmar sign, as it is observed in the palmar arch of the hands. By pressing on the radial artery so as to stop the pulse, those patients suffering from arterio-sclerosis, and especially from aortic insufficiency, feel in the palm of the hand a slight sensation which they compare to the prick of a pin, or the walking of a fly. Out of twenty-four subjects thus examined, in only four was the sign absent. Seven of the twenty suffered from aortic insufficiency. In healthy persons this sign could not be produced.

The explanation of the phenomenon would appear to be that by the compression of the radial artery the cubital artery is congested, and this fact, with the contraction of the hypertophied ventricle, increases the speed of the blood current, increasing in this way the intensity of the shock in the palmar arch. Naturally, the sclerosed condition of the arteries contributes to the production of this sign.

Treatment of Eczema According to the Region.

The treatment of eczema varies according to whether it is local or general. Besides the general treatment, which consists in tonics, arsenic, cod liver oil, and dietary régime, the local treatment might be as follows:—

Scalp.—The first indication is to remove the crusts after cutting the hair as close as possible. This is effected by compresses of boiled water and covered with oil silk, or the application of pure vaseline. Unctions with oil or the warm spray should only be used in women, who should in no case be deprived of their hair.

Once the scalp is well cleaned off, cod oil should be employed:—

Cod oil	5 drachms.
Oil of sweet almonds ...	3 ounces.

This composition is suitable also to eczema of the beard and eyebrows. If it prove inefficient, the following ointment might be prescribed:—

Oxide of zinc	1 drachm.
Calomel	½ drachm.
Vaseline	1 ounce.

Sycosiform eczema of the beard is more rapidly improved by sprays of warm boric acid solution or compresses of

Sulphate of copper	15 grains.
Sulphate of zinc	1 drachm.
Camphor	10 grains.
Water	12 ounces.

or a solution of resorcine (1—100). At night calomel ointment might be applied.

Eczema of the nasal fossæ.—Wash and clean the parts and introduce into the cavities plugs of cotton coated with an ointment of calomel, tannin, or oxide of zinc at 1—10.

Lips.—Very difficult to cure. Apply each night a band of caoutchouc, and during the day an astringent lotion of tannin (1—30), followed by zinc ointment.

Eyelids.—Apply emollient compresses and treat the conjunctivitis by astringent instillations of

Burnt alum	2 grains.
Water	3 drachms.

At night:—

Yellow oxide of mercury ...	6 grains.
Vaseline	1 ounce.

Ear.—Long and tedious to cure. After reducing the inflammation by the usual moist compresses, apply cod oil.

Anus.—Same treatment. If any fissures exist, they should be cauterised. The itching will be best treated by warm lotions of chloral (5—1,000) or phenic acid (1—100), or menthol as ointment.

Scrotum.—Poultices of starch or potato-flour and an ointment of

Dermatol	1 drachm.
Oxide of zinc	1 drachm.
Lanoline	4 drachms.
Vaseline	4 drachms.

Vulva.—Very tenacious, and is the cause of perpetual torment to patients on account of the pruritus accompanying the eczema. Apply moist compresses, ointments of calomel, oxide of zinc, dermatol, and chloral lotions for the itching.

Lower limbs.—Rest, and later on:—

Cod oil	2 drachms.
Oxide of zinc	3 drachms.
Vaseline	6 drachms.

Horny Eczema of the Hands and Feet.—Soften the parts with an alcoholic solution of soft soap, and apply pure cod oil or an ointment of salicylic acid (1—20).

The same treatment for eczema of the nails.

GERMANY.

Berlin, Sept. 20th, 1906.

A paper on

Vegetable Diet,

by Dr. Staehlin, Basel, appears in the *Korr-Bl. f. Sch.-Aerzte.* From his investigations he draws the conclusion that the flesh extractives (which we are only incompletely acquainted with) possess a diuretic action, and that similar material must be contained in eggs. They not only increase the elimination of water, but also of chloride of sodium. In regard to the mechanism of this we know that it partly takes place through lessened giving-off of watery vapour. From some experiments, however, we must conclude that the body may, under some circumstances, become poor with water. This perhaps explains why persons who are nourished almost exclusively on potatoes frequently have a puffed-out appearance. This diuretic property of meat extractives must depend on a direct action on the kidneys, as the circulation is so little affected by a meat diet. One might think that the kidney parenchyma was directly irritated, and this irritation may, under certain circumstances, be injurious. The same thing seems to be said as to eggs, that have the same diuretic properties, and that in large quantities are injurious to the kidneys. We know too little, however, in regard to the mechanism of kidney secretion to be able to make any positive statement. On the other hand, we see from the experiments that there is no sense in forbidding the flesh of warm-blooded animals in kidney diseases, and allowing fish. It has also been proved that the distinction between dark and white meats has absolutely no foundation. Fish has no less effect on the kidneys than beef, but, on the contrary, a greater.

The results are a warning as to allowing meat in chronic kidney disease. Meat demands more work from the kidneys. In chronic disease the organ may be unable to dispose of certain solid material, and especially urea and sodium chloride, and here one sees that meat must be injurious. In milk-feeding the small excretion of chlorine is very advantageous; on the other hand, a good deal of solid material and much water must be excreted. We might, therefore, consider a vegetable diet in kidney diseases more than we have done, but we must not forget, however, that under careful clinical observation meat has not shown itself so injurious as was at one time believed, and that the raising of the general condition would in many patients be prevented by a too one-sided diet.

On the diminished requirements for water in vegetable diet depends what has been frequently observed in the Basel Bürgerhospital, viz., when the diet is a vegetable one, the alcohol habit is much more easily treated than when meat is allowed. The author believes that one must gain the impression that vege-

tarianism is not only a fact, but that physicians must see in it an enrichment from methods of treatment. It is true, however, that much work will be required before we have thoroughly defined the limit of its indications.

MORPHIA IN ACUTE ŒDEMA OF THE LUNGS.

The *Deutsch. Med. Zeit.* has a reference (September 20th) to a paper on the subject by Dr. C. J. Ellefsen. It is known that, as a rule, where respiration is affected, morphia is looked upon by the majority of medical men with suspicion, and certainly as something more likely to do harm than good. Acute œdema of the lungs, as usually met with in elderly people with stenosis of their coronary arteries, or of the aorta, is in more cases treated with excitants, in some cases with venesection, or with sodium or potassium iodide. Concerning morphia, in steno-cardiac attacks it is almost indispensable; the general consensus of opinion is that when the stenocardia causes over-fulness in the lesser circulation and in the pulmonary capillaries, morphia is out of place. Huchard characterises it as useless and dangerous in such conditions.

That the categorical judgment is not always the correct one is beyond doubt, and every experienced practitioner will freely confess that when an effect has to be produced rapidly, and it must especially be so in these threatening conditions, when a quietening effect must be produced on the heart, so that it may do its work calmly and with greater effect, morphia is a valuable and a more reliable remedy than the newer ones: caffeine, theobromine, spanteine, and the like. A case of œdema of the lungs—with very threatening symptoms—treated recently has strengthened this conception anew.

A labourer, aged 50, who, considering his years, had a very marked arterio-sclerosis, came under treatment about a year ago with periodical stenocardiac attacks, with the usual symtoms of violent palpitation, irregular, very frequent, barely palpable pulse, etc. The attacks always came on at night.

Morphia in doses of 1 to 1½ cgm. was given, and after the attacks digitalis and sodi-iodide. The morphia always relieved the attacks, and then gradually diminished in frequency, and then ceased. In the intervals between the attacks albumen occasionally appeared in the urine. About the middle of February, some days after an attack, the patient had an attack of right-sided cerebral apoplexy, with complete loss of consciousness. The patient lay six days in a state of coma, and for days had Cheyne-Stokes respiration.

Contrary to all expectations he recovered consciousness, the paralytic symptoms of the left side disappeared rather quickly, and the general condition improved, until on March 19th, in the night, he had another stenocardiac attack. Considering his weakened condition after the apoplexy, the medical attendant was afraid to give him the morphia that had always been so useful before, and ordered caffeino-sodium benzoiceine in the usual doses, but it was quite useless, the weak, irregular pulse was barely to be counted. Mucous râles developed all over the lungs, with bloody expectoration and unceasing cough, along with all the signs of approaching collapse, cyanosis, cold extremities. Consciousness was clear.

1 cgm. of morphia was now ordered, and half an hour later another ¾ cgm., with the result that the tormenting cough ceased, and also the cardiac restlessness. The pulse improved, became slower—84—and regular. He slept for several hours. Some expectoration of bloody mucous continued still for several weeks, until the alveoli and bronchi had got rid of all the blood that had been poured into them, but the general condition of the patient improved rapidly otherwise.

Such an action of morphia under similar circumstances is certainly not unknown, but the case belongs to the rarities when all the other circumstances are taken into consideration, and one must agree that morphia proved efficacious as compared with the useless and ineffective caffeine.

AUSTRIA.

Vienna, Sept. 30th, 1906.

GUN-SHOT WOUND.

VITEK, at the Prague meeting, exhibited a young man from whom he had removed a bullet which had penetrated the muscles of the neck, lodging in the spine, about the third cervical vertebra. This was followed with a temporary paresis of the right hand, and atrophy of the flexors of both hand and arm. The ulnar and median nerves were entire, hence the trophic root of those nerves was the only destruction done which has lately been designated "Klumpke's root paralysis." There was no disturbance of the sensibility, neither oculopupillary changes.

CHRONIC PROGRESSIVE MUSCULAR ATROPHY.

He also showed a man, æt. 24, who in his childhood had suffered from acute poliomyelitis. A few years after recovery, chronic progressive muscular atrophy commenced, with atrophic paresis in the muscles of the sound side—fibrillary contractions, degenerative reaction, and loss of sensibility. It would appear that the poliomyelitis in the anterior horn, when a child, was the cause of this later development of the chronic process.

TETANUS.

Vanysek showed an interesting case of a boy, æt. 6, who got one of his toes injured with a stone. The toe healed up, but on the ninth day his jaws became locked and on the eleventh all the muscles of the body were rigid. The most peculiar point in the case was the irregular contractions in the calf of both legs, which gave the feet every appearance of *pes equinus*. This condition lingered long before it disappeared.

DERMATITIS EXFOLIATIVA.

Samberger brought forward a female, æt. 55, who had suffered from a severe attack of dermatitis, which commenced with a pustular eruption and lasted for one and a half years. The body was red and infiltrated with hyper-keratotic deposits *de capite ad calcem*.

RAYNAUD'S DISEASE.

Pelnàck demonstrated on a female, æt. 34, a typical form of local asphyxia, which now goes by the name of Raynaud's disease, who described it in 1862. No cause can be assigned in this case for the origin of the disease, and its ætiology is equally obscure. The fingers were symmetrically gangrenous. Before the disease appeared she seems to have had a good deal of nervous disturbance in the shape of neurotic œdema, paræsthesia and "local syncope." Sodii salicylate and warm baths hastened the separation of the gangrenous substance with subsequent healing.

CLIMACTERIC NEUROSIS.

He gave the history of another case where the female had been emasculated about the age of 31 years. Immediately after the operation of castration, neurotic symptoms set in which have increased to the climacteric period. Every drug in the Pharmacopœia was tried, but without relief. Rushing of blood to the head and hands, paræsthesia in the right leg producing a kind of *Claudicatia intermittens* and somnolence; a continuous sleep lasting from one to five days at a time, and frequent polyuria.

ORAL TUBERCULOSIS.

No fixed channel for the introduction of tubercle can be determined—alimentary canal or air passages. Hlava records the case of a dead child in whose mouth he found the tubercular microbe, with swelling of the submaxillary glands resembling a lymphoma. There was also swelling of the tonsils resembling tubercular hyperplasia. There were also lymphoma in the neck and infiltration in the larynx.

ALKALINE BUTTERMILK.

Moll praises the use of alkaline buttermilk, which can be had dry or in powder, in the case of weak children, or in those cases where mothers have insufficient food. In all gastric diseases it is invaluable.

HUNGARY.

Budapest, Sept. 30th, 1906.

At the recent meeting of the Interhospital Medical Association, Dr. Hann gave an excellent summary of the views held at the present day of

Tuberculosis and Pregnancy.

He also reported five cases which came under his own observation. He regarded pregnancy as a severe complication in tuberculosis, the severity of which increases with each pregnancy. Important among the prophylactic measures should be the prevention of conception among tuberculous women. If pregnancy has taken place the woman should be kept under careful medical observation, and if the tuberculous disease grows worse, abortion should be strongly recommended. During the later months of pregnancy the induction of premature labour does not offer any advantages over labour at full term, and is fraught with serious consequences for a tuberculous patient. Moreover, as a tuberculous mother may give birth to a healthy child with fair chances of good health later on, it would be unfair to needlessly sacrifice the life of the infant. Dr. Hann does not believe in universally interrupting the pregnancy as advocated by Maragliano, of Hamburg.

Dr. Temesváry read a very interesting paper on

The Blood and Urine in Eclampsia.

For the purpose of deciding whether eclampsia is a consequence of insufficient renal activity, and can therefore be ascribed to a uræmic intoxication, he carried on investigations. An explanation of this should be secured from examinations of both blood and urine. Before any opinion can be expressed on abnormal conditions, it is necessary to be acquainted with the normal relations of blood and urine as found in healthy pregnant women. The same author has already shown that the physiological composition of blood and urine in pregnancy varies considerably from the non-pregnant state. From an examination of a large number of specimens of the blood taken from eclamptic cases, he did not find any points upon which the uræmic etiology of the diseases can be based. There is a diminution in the alkalinity of the blood, and at times an increased molecular concentration, together with a larger amount of crystalloidal nitrogenous bodies; but these must be considered as an accompaniment of the diminished diuresis, which is usually present during the course of the disease. The factors just enumerated are subject to greater variations in the blood of eclampsia patients than otherwise. The most noteworthy appearance in eclamptic blood is the extreme variation in the quantity of red cells to the quantity of the blood plasma. The blood contains on an average a larger number of red cells, and, in fact, may be compared to "a paste of corpuscles." The rapid disappearance, and even more so, the rapid formation of this condition, shows that the cause of this phenomenon is not to be found in an overproduction of these elements. The proliferation itself does not represent the cause of eclampsia, as it is absent in many instances. Nor does it result from the attacks, as it may appear without any seizures having been present. The only way in which the phenomenon can be explained is that during the course of the disease severe circulatory disturbances occur, as a result of which a considerable amount of plasma leaves the blood. Concerning the urine of normal pregnancy, the author has shown that during twenty-four hours the ammonia salts are slightly increased, and the chlorides are about the same as in the non-pregnant woman. The phosphates are, as is well-known, decreased in amount, this being ascribed to the fœtal bone formation. During labour it was found that less water and salts were excreted by the kidneys than during the period immediately preceding. Especially is the excretion of chlorides diminished; that of the phosphates and ammonia salts is less marked. A very complete series of analyses was then made of the urine of numerous cases of eclampsia. These do not admit of being abstracted, and the results obtained do not lend themselves to an explanation of the manner in which the irritation of the vasomotor centres is produced. Whether this is due to toxic conditions or to a reflex nervous disturbance is therefore still a matter of doubt as far as the author's findings are concerned. If one has to do with a toxæmia, it may be stated with considerable certainty that the poison does not result from insufficiency of the renal function, nor does it leave the body through the kidneys, unless in an entirely changed form a considerable time after the disease has subsided. In other words, for the eliminaton, or, more properly, the destruction of this hypothetical toxin, the renal function is not called into play. The poison, moreover, does not bring about any increase in the molecular concentration of the blood. The changes found in the body in an eclampsia case may also be accounted for without the intermedium of a poison. Dr. Temesváry brings forward the following facts as against the idea that a toxin is present. The earlier the course of the pregnancy or the later in the puerperium the attack comes on, the more severe it is apt to be, and it is more apt to occur with the first labour pains than after these have been present for some time and have produced a toxin or thrown the same into circulation. Although there may be some basis in fact for assuming the toxic theory, the author is inclined to the belief that this is questionable, and that later investigations will show that the eclamptic attack is brought about in some other way, possibly as purely reflex nervous phenomenon.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

ABERDEEN.

THE QUATER-CENTENARY OF ABERDEEN UNIVERSITY.

The celebration of the Quater-Centenary of Aberdeen University last week proved a most brilliant affair. On Tuesday the 25th September the proceedings began with a reception of 3,000 delegates from universities in all parts of the world. A striking feature was a procession of graduates and undergraduates, who marched from Marischal College to the Strathcona Hall. Among the graduates were Lord Strathcona (Chancellor of the University), Sir Frederick Treves (Lord Rector), Lord Aberdeen, the Archbishop of Canterbury, the Right Hon. Mr. Bryce, and Mr. Andrew Carnegie. A short address of welcome was given by Principal Lane to the delegates, who then formally presented their addresses. In the evening a banquet was given by the Corporation to 500 guests, and a torchlight procession was held by the students. On the 26th the honorary degree of LL.D. was conferred on nearly 200 persons, including 150 of the foreign delegates. The Prince of Monaco headed the list, while among those who followed him were the Archbishop of Canterbury, the Bishop of Ripon, Lord Alverstone, Lord Balfour of Burleigh, Mr. Carnegie, the Earl of Elgin, and the following members of the medical profession: Dr. Herbert Mackay Ellis (Directortor General of the Naval Medical Service), Dr. Ferdinand Hueppe (Professor of Hygiene, Prague), Dr. Howard A. Kelly (Professor of Gynæcology, Johns Hopkins University, Baltimore, U.S.A.), Surg. General Sir Alfred Keogh, K.C.B. (Director General Army Medical Service), Sir Francis Laking, Bart., G.C.V.O. (Physician to H.M. the King and the Prince of Wales), Dr. Oscar Liebreich (Professor of Pharmacology, Berlin), Dr. Donald Macalister (President of the General Medical Council), Mr. Edmund Owen (Vice-president of the Royal College of Surgeons of England and Consulting Surgeon of St. Mary's Hospital, Paddington), Rev. Geo. E. Post (Professor of Surgery in the Johanite Hospital, Beirut), Sir Richard Douglas Powell, Bart., K.C.V.O. (President of the Royal College of Physicians of London), Major Ronald Ross, C.B., F.R.S. (Professor of Tropical Medicine in the University of Liverpool), Dr. Frederick Trendelenberg (Professor of Surgery in the University of

Leipzig), Sir William Turner, K.C.B., F.R.S. (Principal of the University of Edinburgh), Dr. J. William White (Professor of Surgery, Pennsylvania University), Sir John Williams, Bart., K.C.V.O. (Late Professor of Midwifery, University College, London). Sir Francis Laking, not having recovered from his recent illness, was carried to the platform in an invalid chair. On the 27th ult. the central event of the celebration took place in the opening of Marischal College. The King and Queen on that day paid a State visit to Aberdeen to open the new buildings at Marischal College. Reaching Aberdeen a quarter of an hour after midday their Majesties were received by Lord Provost Lyon and the magistrates. The Lord Provost having tendered to the King the keys of the city, which he returned, the procession moved off to Marischal College, through streets magnificently decorated and thronged with people.

The Chancellor, Rector, and Principal received their Majesties. King Edward was in Field-Marshal's uniform, and wore the dark green ribbon and insignia of a Knight of the Thistle. Lord Aberdeen, too, displayed on his Lord-Lieutenant's uniform the Order of the Thistle. Principal Lang first read an address.

KING EDWARD thanked them heartily for their cordial welcome, and the Chancellor then presented a gold and jewelled key to his Majesty, who declared the new buildings open.

A pleasing incident followed. Robert Munro, on crutches, of Muirton of Dalvey, in Morayshire, was led in and presented with the Albert Medal for gallantry in endeavouring to save life on the railway at Brodie. He was lamed for life in the attempt. The King pinned the medal on Munro's breast, shook hands with him, and said some kind words of sympathy and commendation.

Their Majesties then inspected a part of the buildings, afterwards driving to the City Chambers, where an address was presented from the Corporation.

In the evening a monster banquet was given by Lord Strathcona, the guests numbering 2,400.

The following letter has been since received by Sir Alexander Lyon, Lord Provost of Aberdeen, from the Right Hon. John Sinclair, Secretary for Scotland:—

"Balmoral Castle, September 27th, 1906.

"Dear Lord Provost,—I am commanded by the King to convey to you the expression of their Majesties' pleasure at their reception to-day by the citizens of Aberdeen. It has given their Majesties great satisfaction to have paid this visit at a moment of much importance in the history of the University of which Aberdeen is so justly proud. The arrangements were well planned and well carried out. The beauty and profusion of the decorations were strikingly effective, and their Majesties were deeply gratified by the loyalty and enthusiasm of the people. Long and familiar associations enshrine the affectionate regard in which their Majesties hold Aberdeenshire and all its interests, and they will cherish a vivid and lasting recollection of the hearty welcome given to them to-day by the city of Aberdeen.—I am, dear Lord Provost, your faithful and obedient servant, JOHN SINCLAIR."

BELFAST.

SANITARY QUESTIONS IN THE CITY.—A public meeting of citizens was held in the Ulster Hall, Belfast, on Thursday evening last, with the object of considering the health of the city, the present outbreak of typhoid, and the action of the Corporation regarding the appointment of a medical superintendent officer of health. About 1,500 persons were present, and the platform was occupied by a number of the most prominent and respected professional and business men. The chair was occupied by Mr. Robert Thompson, J.P., who briefly explained the objects of the meeting, and a series of resolutions was passed practically unanimously. The first stated in general terms that the health of the city was unsatisfactory, and demanded attention. The second was more particular, and ran as follows:—"That the action of the Corporation in fixing the salary to be paid to the new superintendent officer of health at £600 per annum, notwithstanding the repeated recommendations of their own Health Committee, of the Local Government Board, and of the citizens, as also the refusal of the Corporation to make previous experience a condition of the appointment, is unsatisfactory, and the remuneration offered is inadequate." In moving this resolution, Mr. John Sinclair made a good point in comparing the action of the Corporation in this question with their action in appointing a coroner a short time ago. So little was medical knowledge required for this post, that it was frequently filled by a member of the legal profession. Yet they had appointed a medical man at £650 per annum, allowing him to do private practice, which might bring him in as much more. And now they required a skilled medical specialist to devote his whole time to the work, they offered him £600 per annum!

The third resolution called attention to the incident reported in these columns last week, concerning the advertisements for the post not being properly published, and the fourth resolution was to the effect that these resolutions should be widely published, that a deputation should appear before the Corporation on October 1st (the day fixed for making the appointment), to ask that the matter be postponed for further consideration, and, failing this, to take such steps as may be necessary to apply for a Royal Commission of Inquiry into all matters pertaining to the public health of the city of Belfast.

The day after this meeting the Corporation met in Committee to consider the applications which have been received for the post of medical officer of health, and to reduce the number of candidates to six, to appear at the final selection on Monday, October 1st. There were sixteen applications in all, thirteen of them being English or Scotch, and three local. The six chosen on the short list are as follows:—

Dr. George Sampson Moore, Huddersfield; Dr. W. H. Bailie, Belfast; Dr. J. H. Coutts, Blackpool; Dr. Charles O'Neill, Belfast; Dr. James Beatty, Northampton; Dr. Alex. Robb, Paisley.

The local candidates are both general practitioners in the city, Dr. Bailie having been till a few months ago a member of the Corporation. The other four are all specialists in sanitary and public health work. The interest taken by the general public is very marked, as it is recognised that it is a fight to the finish between a party of builders and property-owners, hitherto all-powerful in the Corporation, and a "municipal purity and efficiency party," which has sprung into existence lately.

As we go to press we learn that Dr. W. H. Bailie has been elected.

LETTERS TO THE EDITOR.

THE DECLINING BIRTH-RATE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Your correspondent, "An Obscure Practitioner," appears to me in danger of taking a distorted or exaggerated view of statistics. He writes as follows in your issue September 19th:—"Sir Crichton Browne very wisely laid great stress upon the statistics lately prepared by Mr. David Heron. These statistics prove that the declining birth-rate is most evident amongst the classes having real claim to the designation 'well-bred,' whilst the physically, morally, and socially lower classes are reproducing themselves with the greatest rapidity."

I apprehend, therefore, that to make this sweeping statement of true significance, it would be necessary to prove what is not quite apparent to my way of thinking, and that is that the "physically and morally" weaker members of the British Empire are multiplying nowadays in a greater proportion to the rest of the whole community than they were before the decline of the birth-rate. If this is the case, it goes without saying that racial deterioration has already set in. Indeed, to quote the article in the *Times*, September 14:—"Sir James declares that if we are recruiting our population

from the poorer and mentally and physically feebler stocks of the community at a greater rate than from the better and more capable stocks, then gradual deterioration of the race is inevitable"; the article adding, on its own account—"The proposition is almost a self-evident one." If, then, this state of things is really taking place, criminal statistics and the Registrar-General's death returns will, I presume, ere long offer some evidence on the question. In the meantime, it seems to me that we have no right to infer that because those of a lower social grade are multiplying at a greater rate than heretofore, therefore they necessarily produce proportionately and more unhealthy stock.

I mention this point because I note your correspondent refers to the designation "well-bred." I scarcely need remind him—at least, I take it so—that as far as the maintenance and integrity of the State are concerned, social status has little to do with the question of racial deterioration. It matters not from what social grade of the community the population are recruited, provided always they are begotten from healthy progenitors, healthy, morally and physically. Provided, therefore, the agricultural labourer produce as healthy offspring as the nobleman or any other, both are equal for racial advantages. Indeed, it may be, for aught we know, to the advantage of a civilised nation in periods of its history that an excessive preponderance of its births should devolve upon its more humble yet hardy denizens, so as to counteract the *ennui* arising from the excessive luxury and indulgence of its more affluent members, which in the past have usually preceded the decay of nations. On the other hand, I should be glad if your correspondent could refer me to any historian who has shown that a declining birth-rate has been the cause *per se* (other factors being favourable) of a nation's downfall. Public opinion, I believe, regards a declining birth-rate at the present congested state of our country somewhat analogous to what our profession regards veneseotion in a plethoric state of the system—that is, a means of warding off worse conditions. Whether, however, excessive luxury or a declining birth-rate will more speedily enfeeble a nation is questionable. Common-sense, however, seems to suggest that a nation multiplying at a greater rate than either the State or its individual members can make provision for, is about equivalent in "the struggle for existence" to the augmentation of troops in warfare without food, raiment or shelter.

I am, Sir, yours truly,

CLEMENT H. SERS.

Brighton, September 27th, 1906.

OBITUARY.

WILLIAM WYLLIE, M.D. (GLAS.).

DR. WYLLIE, of Kirkby Lonsdale, died suddenly on September 9th, shortly after being knocked down at a pony race. Dr. Wyllie was born in 1845, at Gourock, where his father was in practice as a medical man. He graduated at Glasgow University, where he took his M.D. After qualifying, he made several voyages as ship's doctor. In 1873 he purchased the Kirkby Lonsdale practice of Dr. David Page, who was the county medical officer. In 1879, Dr. Wyllie became medical officer to the Kirkby Lonsdale Local Board, a position which he continued to hold under the Urban District Council, and which he filled to the time of his death. For 32 years he had been medical officer for the Kirkby Lonsdale District of the Kendal Union, succeeding Dr. Whittaker in this capacity, and he was also medical officer for a portion of the Lunesdale Union. He was for 33 years medical attendant for the local Rechabites and had been doctor to the Oddfellows and Druids' clubs for 25 years, being also vice-president of the widows' and orphans' fund of the Loyal Lonsdale Lodge of Oddfellows. He was a keen supporter of friendly societies, and had endeared himself to the members of many households. As a medical practitioner he was highly respected and esteemed. He was of a kindly disposition, and he took a close interest in the welfare of his patients.

DR. J. E. NEILD, OF MELBOURNE.

IT is not often that medicine and the drama go hand in hand, but by the death of Dr. J. E. Neild, Melbourne has lost its leading dramatic critic. His journalistic connection with the theatre began sixty years ago, when he was a medical student in London. For fifty years Dr. Neild's dramatic criticisms carried great weight with the play-going public in Australia. Simultaneously he carried on a large medical practice, edited the *Australian Medical Journal*, and lectured to the medical students of Melbourne University.

WHITLEY BLAND STOKES, M.A., M.D., R.U.I., F.R.C.S. (ENG.).

THE death is announced of Dr. Whitley Bland Stokes, of Onslow Square, South Kensington. He was a Fellow of the Royal College of Surgeons, Ireland, and took his M.D. degree in Dublin in 1895. He became a member of the Royal College of Physicians, London, in 1895, and a Fellow of the Royal College of Surgeons, England, in 1899. Deceased served in the Army Medical Service, in which he attained the rank of Surgeon-Captain. He filled various posts, among them that of Medical Registrar at St. George's Hospital.

ROBERT S. STEWART, M.D. (GLAS.), OF BRIDGEND.

WE regret to announce the death, on the 28th ult., of Dr. R. S. Stewart, medical superintendent of the County Asylum at Bridgend, Glamorganshire. Deceased was educated medically at the University of Glasgow, where he took the degree of M.B. and of M.D. with honours, in 1883 and 1886 respectively. His appointment to the Glamorganshire County Asylum dates only from three years ago. His contributions to the literature of insanity were numerous and valuable, and some of them dealt with the wider relations of mental pathology to the outside community. The cause of death was heart disease.

SPECIAL ARTICLE.

THE METROPOLITAN HOSPITAL SUNDAY FUND AND THE BRITISH MEDICAL ASSOCIATION.

MEMORANDUM on the Petition and Draft Charter of the Metropolitan Hospital Sunday Fund adopted by the Council of the Metropolitan Counties Branch of the British Medical Association at a Meeting held on September 25th, 1906, and submitted on behalf of the Metropolitan Counties Branch of the British Medical Association to the Lord President of His Majesty's Privy Council on September 29th, 1906.

With reference to the Petition of the Council of the Metropolitan Hospital Sunday Fund, praying His Majesty for the Grant of a Royal Charter of Incorporation, we, the undersigned, in the name of and for, and on behalf of the Metropolitan Counties Branch of the British Medical Association, comprising 2,700 medical practitioners resident in London, believing that we represent the views of the great majority of the medical profession within the Metropolitan area, beg most humbly to submit the following points in relation to the Charter in question, namely:—

I. That the Metropolitan Hospital Sunday Fund, by its power of determining the conditions upon which contributions to hospitals should be granted, exercises a controlling influence upon the administration of London Hospitals, and the Petition for a Charter by that Fund is therefore a matter of deep concern to the whole of the medical profession, not only to those

practitioners who staff the various Hospitals, but also to those who are not so attached.

II. That it has not been sufficiently recognised that Hospitals depend for their existence probably as much upon the gratuitous services of members of the medical profession as upon the monetary gifts of the charitable public, and that all medical practitioners, even those not on the staff of any Hospital, are therefore deeply interested in the administration of Hospitals.

III. That the constitution of the Metropolitan Hospital Sunday Fund fails to provide for any representation, in its Council and in its Committee of Distribution, of medical practitioners, who could best guide it in dealing with the medical requirements of Hospitals, and that the public interest thereby suffers.

IV. That while admitting cordially the beneficent work carried out by the Metropolitan Hospital Sunday Fund in many respects, we are constrained to recognise that this Fund, as almoners of money collected by public subscriptions, has failed to exercise as much influence as might have been expected in removing such serious defects in our Hospital system as are submitted below, viz. :—

(1) That the out-patient departments of London Hospitals, as at present conducted, have a pauperising effect on the patients, through the indiscriminate treatment of applicants whose cases are more suited for reference either to provident dispensaries, or to private practitioners, or to the Poor Law, and that the treatment in out-patient departments of cases that present themselves is frequently ineffective owing to the large numbers of such patients and the absence of that home supervision which many of the cases require.

(2) That the small payments exacted from patients in several Hospitals in London which are subsidised by the Metropolitan Hospital Sunday Fund undoubtedly augment the moral injury to patients by creating a false idea that sufficient payment is being made, and are more unfair to private practitioners and provident dispensaries in the neighbourhood of such Hospitals than absolutely gratuitous attendance. It must be understood, however, that this does not apply to cottage Hospitals where payments for maintenance are made and patients treated by their own medical attendants.

(3) That in our opinion the out-patient departments should only be used for important and selected cases referred for consultation by private practitioners or provident dispensaries, and thus centres of clinical interest would be created to the great advantage of scientific medicine and surgery and the improvement of material for clinical teaching.

(4) That the casualty departments of General Hospitals are especially abused by the admission of trivial cases of accident and sudden illness which might quite well be treated elsewhere, and, while we perfectly recognise the necessity of supplying first-aid without question to really urgent cases, there is, in our opinion, no justification for the very large numbers who obtain gratuitous treatment in the casualty departments of such hospitals.

(5) That while regarding the employment of trained almoners in all departments of Hospitals as indispensable, we are of opinion that subscribers' letters should be abolished, and, so far at least as clinical suitability for Hospital treatment is concerned, medical practitioners should alone recommend.

(6) That the existing efforts to promote forethought, thrift, and independence among the working classes by means of provident dispensaries would, in our opinion, be more successful if the competition of out-patient departments and free dispensaries were removed.

(7) That many of the out-patients of Hospitals belong to the destitute class, who are fit subjects for treatment under the Poor Law, apart from economical considerations, as it is not so much the mere administration of physic as food and other comforts which they require.

(8) That the Hospitals to a great extent compete with and encroach on the field of work and limit the experience of medical practitioners by undertaking cases which are neither clinically nor financially suited for hospital treatment, to the ultimate detriment of public interests.

V. That the co-ordination and co-operation of Hospitals and other medical charities, and of members of the medical profession practising in the Metropolis, are especially necessary in the Metropolitan area for the removal of the abuses which we have noted, and in our opinion an important step towards this would be attained by securing the adequate representation of the medical profession upon the council of the Hospital Sunday Fund as constituted in the proposed charter.

We would, therefore, humbly pray that all the matters set forth in this memorandum may receive favourable consideration, and to this end we crave that His Majesty may be pleased to withhold his sanction to the grant of the proposed Royal Charter of Incorporation to the Metropolitan Hospital Sunday Fund in its present form.

Signed, on behalf of the Metropolitan Counties Branch of the British Medical Association, and by order of the Council of the said branch, by

HUGH R. KER, F.R.C.S. Edin. (President of the Metropolitan Counties Branch, British Medical Association).

J. FORD ANDERSON, M.D. (Chairman of the Medical Charities Committee of the Metropolitan Counties Branch, British Medical Association).

September 29th, 1906.

REVIEWS OF BOOKS.

ORGANOTHERAPY.

THIS voume is apparently the first of a contemplated series of works, intended to uphold the general principles of organotherapy, and to place that method of treatment on a thoroughly scientific basis. Judging from the present book, the authors are determined to spare no pains in making their exposition complete down to the smallest details, and, from their method of writing, are evidently masters, in every sense of the word, of their subject. After a brief historical introduction, the "objects of a rational organotherapy" are discussed at length, and stress is laid upon the importance of only employing the isolated active principles of the various organs concerned, instead of, as till the last few years has been customary, emulsions, infusions, and extracts of the entire organs. That it is now possible to obtain the active substances in a pure form has been demonstrated in the case of adrenalin and spermin at least, and there is considerable hope that similar success will be met with in the case of other glands. The action of these active principles is regarded as a process of katalysis, analogous in almost every way to ordinary ferment action, except that in the case of the two substances mentioned the action is a general one on oxidation, instead of being limited and specific. In the same chapter an account is given of the methods at present in use of estimating the energy of body metabolism. This is principally determined by means of Poehl's urosemiological co-efficient, which is in brief the expression of the ratio between the total nitrogen excreted in the urine and the nitrogen excreted in the form of urea. Great stress is laid upon this co-efficient and on other quantitative urinary determinations, and the value of various remedies is judged largely by the influence exerted by them on this metabolic factor. The entire chapter is written in a rather controversial style, and has

(a) "Rational Organotherapy." By Prof. A. von Poehl, Prof. Prince von Tarchanoff, Dr. Alf. Poehl, and Dr. Wachs. Translated from the Russian. Vol. I. London: J. and A. Churchill. 1906.

probably not gained in clearness in the process of translation. It will certainly appeal more to the physiological chemist than to the practising and practical physician. The remainder of the book, about three-quarters, is devoted solely to a description of and discussion of the value of spermin, and also to the methods of administration and indications for its use. Spermin can now be isolated from many tissues of the body and from the blood, although, of course, its main depository within the body appears to be the sexual glands. When administered hypodermically or by the mouth or rectum, it is claimed to exert an important influence on the oxidative processes of the body, as shown by the great increase of urea nitrogen in proportion to the total urinary nitrogen. Animal experiments also seemed to show that the substance possesses powerful nerve tonic properties, and that it may be capable of increasing the resistance power of the body to bacterial disease. These observations, of course, require ample confirmation before they can be accepted, but, on the whole, we are favourably impressed with the statements made and with the proofs given. Less stress can be laid on the clinical cases quoted, though the authors have certainly been indefatigable in their use and study of the remedy in very numerous morbid conditions. They consider it of special value in neurasthenic and anæmic conditions, both of which are characterised by deficient oxidation.

On the whole, we can recommend the work to those who are specially interested in the subject, but the general practitioner will find little to attract him in its pages. As an example of the present advanced position of Russian medicine, the book possesses a special interest.

THE SHIP-SURGEON'S HANDBOOK. (*a*)

This excellent little manual, concise and compact in form, lucid in style, eminently practical throughout, is written by one who has learned to mark and digest the relations of man and medicine as manifest in deep waters. In supplying such a handbook for sea-going medical officers Mr. Elder has earned lasting thanks. Many a recently-qualified man finds himself at sea, figuratively as well as literally, when he attempts to practise the healing art in marine quarters; but this little volume, with its far-seeing and sometimes humorous hints, its suggestions and directions, and common-sense guidance as to treatment, will save from much discomfiture and will smooth what must at the best of times be a position requiring not only knowledge of medicine but acquaintance with men, tact and sagacity, patience and perseverance, discretion and courage. The volume is full of information on the choice of a ship, selection of outfit, duties on board, details as to practice, and emergency appliances.

There is a very interesting and valuable section on sea-sickness, a perusal of which might benefit all sea-going travellers. In addition to all kinds of details of a most practical character there is a very useful list of steamship lines, giving addresses of head-offices, routes, and particulars as to the surgeon's remuneration. We have no hesitation in very warmly commending this admirable little guide, which we venture to think will become an authoritative handbook for all ship's surgeons.

CATARRHAL FEVERS. (*b*)

Much of this monograph on the philosophy and pathology of "the common cold" is reprinted from the *Lancet* and other medical periodicals, but Dr. Prosser White has such definite views on his subject, and expresses them so attractively, that his little work needs no justification. The questions raised open extensive matters for discussion, and we regret that the author, while ably presenting his own views, should not have more fully dealt with the work and opinions of other investigators who have preceded him along the same path of research. After describing the familiar clinical characteristics of "a common cold," the author passes to a consideration of the bacteriology of the affection, and details his own experiments on animals, which are, however, far from convincing, and we venture to think only have indirect bearing on the apparently similar pathological condition when originating "idiopathically" in man. As far as Dr. White's researches go, they seem to substantiate the conclusions of Dr. Edmund Cantley and Dr. M. H. Gordon, and go to show that the Bacillus coryzos segmentosus is capable of producing what we know clinically as "a cold." In the concluding section of the monograph there are many practical suggestions bearing on the prevention and treatment of "catarrhs" which, whatever views we may hold as to the pathology of the condition, will be fruitful in good works so far as the patient is concerned. The volume is a suggestive contribution to a peculiarly perplexing problem.

APPENDICITIS. (*a*)

Among the many excellent works dealing with the vagaries of the vestigial cœcal appendix, which recent years have brought to us, Mr. Lockwood's monograph is destined to occupy a high place as a contribution of permanent value and lasting interest. The work is of special importance in being mainly a record of personal observation and experience, and no mere repetition of the confusing chorus of irresponsible self-selected investigators. The practical and thoroughly serviceable character of the first edition of this work is too well known to need description here, and in the present edition the general plan and arrangement is retained. New observations and new micro-photographs have been added, and the work now contains clinical records of 112 cases and an interesting tabular summary of 200 cases. The work is one which must appeal to both operative surgeons and general practitioners, and the latter will be particularly interested in the concluding chapter on "The After-Treatment of Appendectomy." The volume is excellently printed, beautifully illustrated, and there is a very helpful index.

FIBROID TUMOURS. (*b*)

This work is dedicated to "Suffering women and their responsible advisers." Its preface gives us to understand that it represents a paper which was refused publication by the "British Medical Journal," and by ourselves. So far as we can understand, the reason alleged for its refusal was that the book stated that the risks of operation for fibro-myoma of the uterus are "on the average more than five hundred times greater than those of non-operation." The first line of the text of the book is as follows:—"For the benefit of the non-medical reader . . . it will be desirous to explain some technical terms." The book closes with a glossary of medical terms, in which such words as abdomen, anus, ovary, are defined.

Dr. Shaw has not only furnished us with abundant reasons for refusing to review his book, on the ground that it is a quasi-medical work written, not for the medical profession, but for the public, but he has also given us cause to ask under what rules of medical ethics he considers himself entitled to publish a work which is calculated to cause him "to obtain practice by unworthy means."

We regret to see on the title page that Dr. Shaw is a Fellow (late vice-president) of the British Gynæcological Society.

(*a*) "The Ship-Surgeon's Handbook." By A. Vavasour Elder M.R.C.S., M.R.C.P., Surgeon, Orient Steam Navigation Co. Pp. viii. 167. Crown 8vo. London: Bailliere, Tindall and Cox. 1906. Price 3s. 6d. net.

(*b*) "Catarrhal Fevers, commonly called Colds: Their Causes, Consequences, Control, and Cure." By R. Prosser White. M.D.Edin., M.R.C.S.Eng., Life Vice-President and Honorary Medical Officer, Royal Albert Edward Infirmary, Wigan. Pp. viii., iii. London: H. K. Lewis. 1906.

(*a*) "Appendicitis, its Pathology and Surgery." By Charles Barrett Lockwood, F.R.C.S., Surgeon to St. Bartholomew's Hospital. Pp. 342. Second edition. London: Macmillan and Co., Ltd. 1906. Price 10s. net.

(*b*) "Fibroid Tumours: A New Treatment for Fibroid Tumour and some other Diseases of Women without Operation." By John Shaw, M.D.Lond., M.R.C.P., Physician for Diseases of Women, North-West London Hospital; Fellow British Gynæcological Society. Pp. 80. London: Swan, Sonnenschein and Co. 1906.

MEDICAL NEWS IN BRIEF.

The International Congress for Cancer Research.

THE first International Congress for Cancer Research was, on the 26th inst., formally opened at Heidelberg by the Grand Duke and Duchess of Baden in the presence of numerous medical and municipal representatives from all parts of the world. At the same time a new hospital and laboratory for cancer investigations was opened. The institution has already cost over £40,000, derived partly from public and partly from private sources. The hospital contains fifty beds, sixteen for paying patients, but the laboratories are still incomplete. Papers were afterwards read by Professors von Leyden, on "The Problem of the Curative Treatment of Cancer," Czerny, on "Unexpected Recovery from Cancer," and others. A formal reception in the Town Hall, at which the Grand Duke and Grand Duchess presided, followed by illumination of the Neckar, closed the day's proceedings. Over 400 invitations were sent out to cancer specialists throughout the world by the central committee. Amongst the English representatives present were Dr. Bashford, of the Imperial Cancer Research Fund, Dr. Lazarus-Barlow, of Middlesex Hospital, the entire medical staff of the Cancer Hospital, London, and Dr. Powell White, of Manchester. The Grand Duke and Grand Duchess received all the English representatives most graciously. The Grand Duchess referred to Miss Florence Nightingale and to the indebtedness of Germany to England in nursing and hospital matters.

Opening of the Main Drainage Works in Dublin.

ON the 24th ultimo, the long expected opening of the new main drainage works for the City of Dublin took place in the presence of a large assemblage of prominent Dublin citizens and others. The works, which have occupied more than ten years in their construction, cost over half a million, and will result in an enormous benefit to the entire city. The Chairman of the Committee, to which the task of supervision of the works belonged, in the course of an interesting speech, referred to the method adopted of dealing with the crude sewage. As many of our readers know, the harbour attached to the old Pigeon House Fort which formerly guarded the mouth of the Liffey, but which has now been converted into an electric lighting station, has been altered into a series of precipitation tanks for the reception of the crude sewage. The fluid portion of this sewage is then run off as an almost clear liquid, and, purified by the lime with which it has been treated, is run into the Liffey, while the more solid sludge is carried off through culverts lying below the tanks into a storage chamber from which it is pumped into a sludge steamer specially built for its removal. It is then carried out to sea. As yet it is too soon to appreciate the effect of the new system on the Liffey itself, as there are still several sewers discharging crude sewage into it, and as the low water in the river prevents the bed from receiving a much-needed flushing. With the closage of the last contributory drain, and the advent of a few heavy winter floods, a great change may be expected, and it is hoped that the river will once again return to a normal state.

Metropolitan Hospital Statistics.

STATISTICS showing in some measure the magnitude of the work carried on by the hospital dispensaries, etc., of London have been published by the Distribution Committee of the Hospital Saturday Fund in the fund's September circular, and issued to the collectors in the various contributing workshops and business houses with the October to December collection sheets. The tables have been prepared from the returns received from 152 institutions. They represent the work of these medical charities during 1905. For example, according to the "Summary," the total number of beds at thirty-one general hospitals was 5,748; the average number of beds occupied, 4,795; total number of in-patients, 74,172; total number of separate out-patients; 542,229; total number of separate casualty cases, 584,719; total number of home visits, 55,695; payments made by in-patients, £8,143; payments made by out-patients, £4,941; net income from investments, £143,349; total cost of maintenance, £502,352; total cost of management, £38,063. At the London Hospital, according to the detailed tables, during the past year of the total number of beds—933—at that institution the average number occupied was 741. The total number of in-patients was 13,552; total number of separate out-patients, 86,129; total number of separate casualty cases, 123,143; total number of home visits, 3,944; payments made by in-patients, £116; payments made by out-patients, £1,840; net income from investments, £11,375; total cost of maintenance, £82,801; total cost of management, £3,491. At the Charing Cross Hospital the average number of beds occupied was 169 out of an available total of 238. The total number of in-patients was 2,465; the total number of separate out-patients, 10,167; total number of separate casualty cases, 10,385; total number of home visits, 307. There were no payments by either in or out-patients. The net income from investments was £683; the total cost of maintenance, £18,863; and total cost of management, £2,117.

Prosecution under Dental Acts.

ON a charge of using the title "dentist," implying that he was registered under the Act, George Charles Smith, of 153, High Street, Lewisham, was last week at Greenwich fined 40s. and three guineas costs. The prosecution was at the instance of the British Dental Association.

The defendant said he had been on the dental register since 1878, but through some business regulations he had been struck off the roll. If the summons were adjourned for a month he would comply with the B.D.A.'s requirements.

Mr. Eves, for the prosecution, said that the defendant had been guilty of unprofessional conduct by advertising and employing unqualified persons.

The defendant said it was a case of professional animosity. For twenty-one years he was on the Register, and was the only registered dentist in Lewisham. He had to adopt business methods to compete with other dentists. He asked for an adjournment as he was forming "G. C. Smith, Limited."

Medical Exhibitions.

THE annual Medical Exhibition is being held in London during the whole of the present week, Saturday excepted, at the Royal Horticultural Hall, Westminster. It is arranged and controlled by the proprietors of the *British and Colonial Chemist and Druggist*. Last year's function proved a great success, and as the present is being run on similar lines and is strictly confined to members of the medical profession and all the available space has been taken up, there is every prospect of a successful issue. The exhibition is free to medical men, of whom upwards of 3,000 were present last year. Another venture is contemplated under the title of a "Travel Exhibition." This will open at the Royal Horticultural Hall, Westminster, May 24th to June 8th, 1907, and will graphically illustrate and demonstrate how the public throughout

the world travel, where they travel, the means by which they travel, the thousand-and-one *et ceteras* connected with travel. Manufacturers will be represented by every article required *en route*, whether on a journey of fifty or thousands of miles. The latter exhibition is being organised and arranged by the directors of *Health Resort*.

Delamere Sanatorium New Joint Scheme.

The Manchester Hospital for Consumption and Diseases of the Throat and Chest and the Crossley Sanatorium at Delamere are the subjects of a scheme which has been prepared for their administration, and is under the consideration of the Charity Commissioners under the provisions of the Charitable Trusts Acts, 1853 to 1894. Under the scheme the endowments of the two charities are to be consolidated and managed as one institution under the title of the Manchester Hospital for Consumption and Diseases of the Throat and Chest. The body of trustees for the institution is to consist of sixteen, who shall be entitled to hold office for life. The real estate belonging to the institution includes 8,208 square yards of land at Dunham Massey, with the hospital building on part thereof, 645 square yards of land in Hardman Street, Manchester, with the out-patients' department on it, and seventy-three acres with the sanatorium at Delamere. The personal estate amounts to over £16,000 in respect of the Hospital for Consumption, and over £63,000 in respect of the sanatorium, making together about £80,000,

Transmission by Post of Pathological Specimens.

The Postmaster-General has recently revised the regulations governing the transmission by post of deleterious liquids and substances sent for medical examination or analysis, and on and from the 1st proximo such specimens may be sent by Letter Post, without registration, by qualified medical practitioners and qualified Veterinary surgeons under the following conditions:—

(1) that they are addressed to a laboratory or institute, public or private, or to a medical practitioner or veterinary surgeon within the United Kingdom;

(2) that they are enclosed in a receptacle hermetically sealed, which receptacle must itself be placed in a strong wooden, leather, or metal case in such a way that it cannot shift about, and with a sufficient quantity of some absorbent material (such as sawdust or cotton-wool), so packed about the receptacle as absolutely to prevent any possible leakage from the package in the event of damage to the receptacle;

(3) that they are conspicuously marked "Fragile with Care," and bear the words "Pathological Specimen," and also the signature and address of the medical practitioner or veterinary surgeon who sends them.

The packets must on no account be sent by *Parcel Post*. Any packet of the kind found in the Parcel Post, or found in the Letter Post not packed and marked as directed, will be at once stopped and destroyed with all its wrappings and enclosures.

Any person who sends by post a deleterious liquid or substance for medical examination or analysis otherwise than as provided by these regulations is liable to prosecution.

It is recommended that if receptacles are supplied by a laboratory or institute to medical practitioners or veterinary surgeons, they should be submitted to the General Post Office, in order to ascertain whether they are regarded as complying with the regulations.

Preservatives in Milk.

The Local Government Board, Edinburgh, have issued a circular calling the attention of local authorities to the subject of the addition of preservatives to milk. The Departmental Committee of the Local Government Board for England stated that preservatives were objectionable on the ground of public health, and were also unnecessary for the purpose of the milk trade. The Board accordingly suggest that the local authorities should cause samples of milk to be taken with a view to ascertaining the presence of substances commonly in use as preservatives—*e.g.*, formalin and boric] preservatives. The Board are advised that, as regards formalin and boric preservatives, the presence in milk of formalin to an amount that is ascertained by examination within three days of collecting the sample to exceed 1 part in 40,000 (1 part of formic aldehyde in 100,000) raises a strong presumption that the article has been rendered injurious to health, and that the purchaser has been prejudiced. Similar presumption is raised where boric preservatives are present in milk to an amount exceeding 57 parts of boric acid per 100,000, or 40 grains of boric acid per gallon.

Anthrax in Cheshire.

The following circumstances attending the death of a farm labourer, due to anthrax, have been disclosed at an inquest in Liverpool. About two weeks ago an apparently healthy cow was killed on a farm in Norley, Mid-Cheshire, and after being dressed, was sent to the Manchester Meat Market Traces of anthrax being discovered, several other suspected carcasses and a large number of hides were destroyed. A few days later two farm hands became ill, and were found to be suffering from anthrax. The men were conveyed to the Royal Infirmary at Liverpool, where one rapidly became worse and died. The case of the other is regarded as hopeful.

London Medical Man Robbed.

Edwin John Bell, 22, described as a pianoforte-tuner, of East Finchley, was last week charged at Highgate Police Court, and was sentenced to six months hard labour, for stealing articles, valued at £14 6s. from two surgeries at Muswell Hill. Dr. Lawrenson stated prisoner called two or three times "collecting for lepers," and on the 30th ult. was shown into the surgery. He asked witness to lend him a surgical instrument catalogue, and he took one away with him. Next morning witness missed a case of surgical instruments, value six guineas. Dr. Donald Munro lost a microscope, value £8. Detective Goode arrested prisoner with the case in his pocket. At his lodging he found other surgical instruments. He had been collecting for charities, but had not paid the money over.

PASS LIST.

The Royal University of Ireland.

The following candidates have passed the Second Examination in Medicine:—

Upper Pass.—*Albert V. Craig, *Richard W. G. Hingston, *David Horgan, John C. Houston, *John C. Johnson, Edward G. Kennedy, *Ernest W. Kirwan, *Patrick J. Lydon, *John M. McCloy, *Peter J. Ryan, *William W. D. Thomson, Michael Twohig, *William O. Wilson. Those marked with an asterisk may present themselves for the further examination for honours.

Pass.—Joseph Anderson, William J. Ashby, William Boyd, Francis Bradley, Patrick J. Cullinane, Michael G. Devine, William Dickey, William Doolin, William C. Dunne, B.A., Francis C. Ferran, B.A., William A. Frost, John J. Gilmore, William E. Graham, William Hamilton, James A. Hanrahan, Patrick Hayes, J. Hill, Sarsfield C. Kerrigan, Joshua Keyms, B. A. Bertram C. Letts, Denis Lynch, James McCormick. Samuel K. McKee, William Magner, Thomas C. Magnier, George E. A. Mitchell, Thomas J. S. Moffett, Daniel F. Murnaghan, Harris Newman, Jerome O Flynn, James J. O'Kelly, B.A., James M. O'Reilly, William Paul, David A. Rice, Thomas Scanlan, William Speedy,

WEEKLY SUMMARY OF THE MEDICAL JOURNALS. ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT GYNÆCOLOGICAL AND OBSTETRICAL LITERATURE.

Antistreptococcic Serum as a Prophylactic and Curative Agent.—Fromme (*Münchener Med. Woch.*, 1906, *Nr.* 1) says that laparotomies during which infection may be easily transmitted to the peritoneum, for example in cases of pyosalpinx and carcinoma, make it desirable to render the patient immune to such infection from the very beginning. He has lately made much use of the anti-streptococcic serum for this purpose. He injects 10 to 20 ccm. of Menzer's serum daily with the most favourable results. As regards the use of the serum as a curative agent, it is most important to reserve it for pure streptococcal infections. It must not be used for saprophytic infections. It is very important also that the serum be injected as early as possible. After the formation of a purulent exudate, or when the streptococci have accumulated to an unlimited extent, the serum is contra-indicated. In cases of well-marked pyæmia, advanced septicæmia and advanced peritonitis, the serum may be injurious. Through the destruction of the streptococci, produced by the serum, a large amount of toxic proteins are set free, which may poison the patient. On this account the serum is most useful when dealing with streptococcal endometritis, as the author proved in six cases, because the proteins are discharged from the uterus before they can injure the organism. For the same reason, in order that the serum may be successful in streptococcal peritonitis, incision and drainage are very necessary. G.

Appendicitis and the Puerperium. — A case is described by Duvernay (*Lyon. Med.*, January 1st, 1905) as follows: A woman with slightly contracted pelvis, who had delivered herself spontaneously, developed immediately after her labour a slight rise of temperature. Examination of the genital tract revealed nothing pathological. There was a history of occasional pain in the region of the right kidney, but nothing further. The pulse remained rapid, the lochia normal. The abdomen was neither distended, nor tender to touch. On the eleventh day, the temperature rose to 39·7°. A digital examination was then made of the uterus, and some decidual remains were removed. They showed no signs of decomposition. The uterus was douched and packed. Immediately after this vomiting began, temperature rose to 41·3°, patient became unconscious, and died on the next day. The autopsy revealed pus among the intestines, the genital system in normal puerperal condition, and behind the cæcum, reaching nearly to the kidney, an old abscess in which the appendix was floating. The inner wall of the abscess cavity was perforated. The pressure during parturition, and later the examination and emptying of the uterus, probably produced the perforation, and thus led to the death of the patient. G.

Pemphigus Neonatorum.—Koblanck (*Zeitsch. für Geb. und Gyn.*, Bd. LVII., Hft. 3) describes a case which occurred in a two-para, who had slight vaginal and vesical catarrh during her pregnancy, and in whom there was a remarkably deep position of the fœtal head during the tenth month. The labour, which lasted for sixteen hours, began with rupture of the membranes, with, at the same time, very feeble pains. No internal examination was made. Immediately after its birth, pemphigius blebs the size of hempseeds were discovered on the skin of the body and arms of the child. The palms of the hands and soles of the feet were free. The blebs disappeared in a few days when treated with 70 per cent. alcohol. The child thrived. The mother had a normal puerperium. That it was not syphilitic pemphigus was absolutely certain. The intra-genital origin in this and similar cases is due to the rubbing into the delicate fœtal skin of the staphylococcus aureus during the passage of the child through the vagina. G.

Painless Labour.—Wolff, Berlin (*Archiv. für Gyn.*, Bd. LXXVIII., Hft. 2), describes the progress of a painless labour case which, after lasting for two days, was finished by him with forceps. Neither through the history, nor through examination up to six months post-partum, could any disease of the nervous system be discovered. The woman had no pains whatever; in fact, she would not believe that she was in labour. During the stage of expulsion, bearing-down efforts were absent. The author then describes several examples of this labour from English literature. This partus insensibilis seems to be more frequent than is generally accepted. Even though it has nothing to do with cases of precipitate labour due to an abnormally small amount of resistance, it seems probable that a case of this description is often hidden among the latter. It cannot be denied that painlessness of the labour pains is an early symptom of myelitis or tabes. Still, it may be also possible that the cause must be sought for in a peculiar condition of the genital system, perhaps an especially great dilatability. The absence of bearing-down efforts which is also observed in spinal anæsthesia indicates to us wherein lies the significance of the physiological labour pains, at any rate during the expulsive period. The intimate connection between bearing-down efforts and painful contractions is clearly seen when the labour is painless. Nature requires this intense irritation in order that the bearing-down efforts may be set in motion at the right time, and with all the strength of the woman. G.

Conditions which Contra-indicate and which Render Suckling by the Mother Impossible.—As contra-indications, Bouquet (*Bull. Generale de Therapeutique*, 1906, January 15-30th) mentions all forms of heart disease even when compensated, and albumenuria, but only when the latter is a symptom of Bright's disease, and not of the kidney of pregnancy. Above all, tuberculosis is a contra-indication both for the sake of the mother and child. Again, suckling must be forbidden when the mother suffers from any infectious disease, for example, typhoid, measles, or erysipelas. It is also contra-indicated by the onset of mastitis or the presence of malignant breast tumours. Whether chronic alcoholics should nurse their infants is a very important question. Such nursing can produce disturbances of the intestinal and nervous systems of the child. These disturbances are still more frequent in cases of chronic intoxication from lead, mercury, and arsenic. The author observed a mother who suffered from lead poisoning, and who had nursed her five children herself. They all died at an early age from convulsions. Alterations in the quality of the milk through which it becomes too poor to properly nourish a a child are also found. We cannot at present explain the cause of this with certainty. Suckling can also be impossible on anatomical, physiological, and social grounds. The former are rare; among them are included complete deficiency of the nipples, malformation of the mammæ, and more or less complete failure of secretion. An absolute failure of secretion does not occur. The author describes in conclusion the social grounds which prevent nursing by the mother, their results, and the means by which this evil may be removed.

G.

The Causation of Eclampsia is discussed by Dr. Liepmann (*Münchener Med. Wochensch.*, 1905, No. 51). In his first report he said the toxins are to be sought for in the placenta. In the meantime, further experiments have been made. The results of the intra-peritoneal injection of a solution of the powder prepared from the placenta of an eclamptic were always the same. The placental poison showed the following characteristics:—(1) It is closely incorporated with the albumen molecule; (2) it is very poisonous to rabbits; (3) it is extremely mobile; (4) it may be precipitated by the action of albumen precipitating substances; but (5) it is not yet possible to extract it. The more the poison has advanced into the organism the more convulsions appear, and the less amount of the poison is to be found in the placenta. On the contrary, the fewer the convulsions have been, the more toxic is the placenta. The placenta seems to be the place of formation and of exit of the poison. The latter shows a great affinity for the brain matter which it destroys, but is neutralised by it. Besides this, the poison is very injurious to the kidney parenchyma and to the liver. The injury to the kidney is always secondary to the poisoning. In cases where there is already albumenuria, the amount of the latter may be much increased. Immediate delivery is the best treatment. In connection with it, saline infusion and bleeding are useful. For coma and shallow respirations artificial respiration must be employed. Warm packing has an injurious action. According to Bumm, the profuse sweating concentrates the poison.

Treatment of Eclampsia.—With regard to Liepmann's work and his statistics, Esch (*Münchener Med. Wochensch.*, 1906, No. 15) seeks to show that there is danger of exaggerating the results of immediate delivery. In the Universitäts-Frauenklinik, Berlin, among 36 cases from May 1st, 1905, to January 1st, 1906, immediate delivery gave a mortality of 22.2 per cent., so it may be taken as proved that immediate delivery is not a specific curative agent. One must differentiate between severe and mild cases of eclampsia. When there is little or no coma, free respiration, and a good pulse, the expectant treatment is best. The severity and intensity of the attack is to be judged from its duration, and from its effect on the consciousness, respiration and pulse of the patient. The degree of the attack never changes suddenly. When dealing with multiparæ and primaparæ with dilatable soft parts and a dilating cervix, the membranes may be ruptured. Braxton Hicks' version is generally contra-indicated, because three-fourths of the eclamptics are primaparæ. When the internalos is not at all dilated, the practitioner must make up his mind whether he is in a position to perform rapid delivery, as this may become necessary at any moment. When he is not, he must send the patient to a hospital or call in a specialist. G.

The Causes of Death from Uterine Fibromyomata were found by Pellanda (Lyon, 1905) in 171 cases which ended fatally to be the following:—(1) Cachexia, 9 times (5.2 per cent.), pressure on the abdominal contents, exhaustion from blood loss, constipation, mild infection, phlebitis, heart and kidney changes. (2) Hæmorrhages, 11 times (6.4 per cent.). (3) The most common cause—infection, 85 times (49.5) per cent.). This occurred most frequently in combination with pregnancy, parturition, and premature labour. It is subdivided as follows:—(a) Gangrene, 47 times. Pedunctulated submucous tumours had caused death 9 times, because the drainage from the uterine cavity was not sufficient, and there was absorption; 16 times necrobiosis followed by gangrene and suppuration, which led to septicæmia. Peritonitis arose in 22 cases from rupture of the gangrenous mass into the peritoneum. (b) Rupture of a pyosalpinx, which occurred in 19 cases. (c) Peritonitis, which in some cases was complicated with pyæmia, was caused in 19 cases by degeneration of the tumours themselves or the adnexæ. (4) Compression of the abdominal and pelvic contents in 44 cases (25.8 per cent.), occlusion of the intestine occurring 20 times; pressure on the metra causing albumenuria, pyelonephritis, uræmia, 13 times. Pressure on the uterus vagina or the bladder, 11 times. (5) Thrombosis of the pelvic veins and pulmonary embolism and cardiac degeneration caused death 19 times (11.1 per cent.). (6) Twisting of the pedicle of a subserous fibromyoma. (7) Cases of pregnancy complicated with fibroids and malignant degeneration of the tumours are not included. Regarding the connection between fibromyoma and carcinoma, the greater frequency of carcinoma of the body of the uterus must be specially mentioned. The average age of death in the 171 cases was 47 years and 9 months. In the cases due to infection, death was earlier—42 years and 8 months. In cachexia, later—57 years and 5 months. Most deaths occurred between 36 and 42 and between 46 and 50, a very small number before 30 and after 60. In conclusion, the author says that, since death from fibromyomata is the exception, not the rule, operation is only needed where complications supervene, where the tumours increase in size after the menopause, or where their size makes it impossible for the patient to perform her daily duties. G.

Malignant Uterine Myomata.—Concerning these, Villard (Lyon, 1905) says, among other remarks, that myomata may undergo sarcomatous degeneration, especially at the time of and after the menopause. Rapid growth and the reappearance of uterine hæmorrhage after the menopause are the best clinical signs. Ascites and cachexia are not of so much value. Malignant myomata may be confused with cancer of the body, with pregnancy in a fibroid uterus, solid or cystic tumours of the ovary, and peritoneal cancer. The frequency of malignant degeneration is difficult to estimate. G.

Abdominal Myomectomy.—M. Bonier (Lyon, 1904) says the ideal procedure is to combine the removal of the tumours with the preservation of the uterus, especially when we are dealing with benign tumours. This is nearly always possible, since the tumours are generally circumscribed and without adhesions. In this way menstruation and fertility are preserved, and such unpleasant results as the premature menopause and atrophy of the vagina are prevented. A very profuse development of tumours, and the diffuse form, indicate hysterectomy. The younger the woman the greater must be our efforts to make the operation as conservative as possible. Cases of pregnancy after myomectomy are fairly frequent. Deeply-lying fibromyomata must always be removed, since they may interfere with pregnancy or parturition. Myomectomy is more dangerous and more difficult than hysterectomy, but the later results prove its superiority. Recurrence of the fibroids is very rare. G.

Gonorrhœa and the Puerperium.—Meyer (*Monatssch. f. Geb. und Gyn.*, June, 1906) says puerperal gonorrhœa is a much more dangerous complication than it is usually considered to be. It can produce high fever (40 deg.), and severe general infection, with rigors, giving the clinical picture of a septic condition. How much this general infection is due to toxic poisoning or the invasion of the circulation by gonococci, cannot yet be determined. Remissions and intermissions of the fever, with febrile periods lasting for some days, is not an absolute proof of puerperal gonorrhœa. The generally accepted idea that late fever is characteristic of gonorrhœa must not always be accepted. Whether the gonorrhœal endometrium is unfavourable to the proper formation of the placenta, or whether the growing ovum may be influenced by poisoning from toxins due to the gonococci, cannot yet be decided. G.

Mr. J. S. McArdle will deliver an address introductory to the Medical Session in the Theatre of St. Vincent's] Hospital, Dublin, on the 9th inst., at 4.30 p.m.

NOTICES TO CORRESPONDENTS, &c.

☞ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to 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.

J. L. WATSON.—Although formaldehyde as a preservative undoubtedly exhibits the growth of bacteria, it does not kill tubercle bacilli in milk even in a 1-5,000 solution. There is some evidence that 1-10,000 solution can cause injury to the mucous membrane of the child's intestines.

METHYLENE.—Gonococci may be stained by methylene blue. It is said that even 1-10,000 for 10 seconds will demonstrate them.

READER.—You can still get W. E. Henley's little book "In Hospital." The poems form a record of his experience in the Edinburgh Infirmary in the early seventies. His work, either medical or poetical, was never impaired by his exhausting illness, tuberculous arthritis.

DR. S. (Bath).—You will get comparatively little for your books. Some could be disposed of privately, but a dealer will only give you so much a hundred. Books which have cost 35s. often go for 5s.

MR. J. H. H. (Manchester).—We cannot undertake the experimental enquiry to remove your objections as you suggest. This work has already been done by others, but it has not convinced you, nor would any further facts we could adduce remove your prejudice.

INSTRUCTOR (Edinburgh).—The new work on Anatomy, by Prof. Buchanan, has, we understand, already proved its need by a strong demand. The book is fully referred to in our last issue.

R. H. M.—Nitric oxide combines with hæmoglobin and forms NO-hæmoglobin.

MOLAR.—The draft of the Ordinance for regulating the qualification and providing for the Registration of Dentists in Hong Kong was forwarded to, and considered by, the General Medical Council on Feb. 26th, 1906.

C. T. M.—Yes, gelatine does give a violet blue reaction.

A. H.—The motion to appoint a Dublin surgeon instead of an English or Scotch one at the Apothecaries' Hall, Dublin, was withdrawn by the proposer.

ACTINOMYCOSIS.—You are right in saying that the ray fungus was first found in pus from the human subject.

CANADA.—The virulence of anthrax bacilli are destroyed by putrefaction, but the spores are not affected.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, OCTOBER 3rd.

OBSTETRICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8 p.m.: Specimens will be shown by Dr. Eden, Dr. R. D. Maxwell, and Dr. H. R. Andrews. Short Communication:—Dr. Eden and Mr. F. L. Provis: A Case of Intra-ligamentous, Fibro-cystic Tumour of the Uterus, weighing about 30 pounds, Successfully Removed by Enucleation and Sub-total Hysterectomy. Paper:—Mr. E. E. Young: Primary Tuberculosis of the Cervix.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—10 a.m.: Diseases of the Throat, Nose, and Ear. Diseases of Children. 2 p.m.: Medical and Surgical Clinics. 2.30 p.m.: X-Rays. Operations.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. T. P. Legg: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. G. H. Savage: Lucid Intervals in Cases of Insanity.

THURSDAY, OCTOBER 4th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—2 p.m.: Medical and Surgical Clinics. 2.30 p.m.: X-Rays. Operations. Diseases of the Eye.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m.: Lecture:—Dr. G. F. Still: Head-nodding and other Curious Movements in Children.

FRIDAY, OCTOBER 5th.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.—8.30 p.m.: Presidential Address:—Dr. L. Mark: Art and Medicine.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—2 p.m.: Medical and Surgical Clinics. 2.15 p.m. Diseases of the Throat, Nose, and Ear. 2.30 p.m.: X-Rays. Operations. Diseases of the Skin.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Dr. D. Grant. Clinique. (Ear.)

SATURDAY, OCTOBER 6th.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—10 a.m.: Diseases of the Throat, Nose, and Ear. 2 p.m.: Medical and Surgical Clinics. 2.30 p.m.: X-Rays. Operations.

MONDAY, OCTOBER 8th.

THE MEDICAL SOCIETY OF LONDON.—8.30 p.m: First Ordinary Meeting of the Session 1906-7. Mr. Charles A. Ballance, M.V.O., M.S. (incoming President): Opening Address. Mr. T. H. Kellock: Paper:—"Actinomycosis of the Vermiform Appendix."

Vacancies.

Birmingham Queen's Hospital.—Pathologist. Salary £100 per annum. Applications to the Secretary.

Cheshire County Asylum, Macclesfield.—Junior Assistant Medical Officer. Salary £140 per annum, with apartments, board (no alcohol), and washing. Applications to the Medical Superintendent.

City of Birmingham Asylum, Rubery Hill, near Birmingham.—Male Junior Assistant Medical Officer. Salary £150 per annum, with furnished apartments, board, &c. Applications to the Medical Superintendent.

City of Liverpool.—Assistant Medical Officer of Health. Salary £250 per annum. Applications to Edward R. Pickmere, Town Clerk, Town Clerk's Office, Liverpool.

City of Liverpool.—Infectious Diseases Hospital.—Assistant Resident Medical Officer. Salary £120 per annum, together with board, washing, and lodging at the Hospital. Applications to Edward R. Pickmere, Town Clerk, Town Clerk's Office, Liverpool.

Egyptian Government.—Ministry of Education.—Professor of Midwifery and Gynæcology. Salary £400 a year, with private practice. Applications to the Director, School of Medicine, Cairo, Egypt.

Egyptian Government.—Ministry of Education.—Medical Tutor and Registrar to Kasr-El-Ainy Hospital. Salary £400 a year. No private practice. Applications to the Director, School of Medicine, Cairo, Egypt.

Manchester Royal Infirmary and Dispensary. Honorary Assistant Physician. Applications to the Chairman of the Elective Committee, on or before October 31st. (See advt.)

Royal Victoria Eye and Ear Hospital.—House Surgeon. Immediate application to the Registrar, Adelaide Road, Dublin. (See advt.)

Staffordshire County Asylum, Cheddleton, Leek.—Assistant Medical Officer. Salary £150 per annum, with furnished quarters, board, and washing. Applications to the Medical Superintendent.

The Finsbury Dispensary, Brewer Street, Goswell Road, E.C.—Resident Medical Officer. Salary £140 per annum, with furnished residence in the institution, with attendance, coals, and gas. Applications to W. H. Pratt, Secretary.

The Royal Portsmouth Hospital, Portsmouth.—House Surgeon. Salary £100 per annum, with board, residence, and laundry. Applications to B. Wagstaff, Secretary.

Wolverhampton and Staffordshire General Hospital.—House Physician. Salary £100 per annum, with board, lodging, and laundry. Applications to J. Stephen Neil, House Governor and Secretary, Wolverhampton.

Appointments.

CASHMAN, JAMES P., M.B., B.S.R.U.I., Resident Medical Superintendent of the Cork District Asylum.

DAWNAY, A. H. PAYAN, M.R.C.S., L.R.C.P.Lond., Honorary Ophthalmic Surgeon to the Hounslow Hospital.

JEPHCOTT, CHARLES, M.B., B.S.Cantab., L.R.C.P.Lond., M.R.C.S., Medical Officer to the Chester Union by the Chester Board of Guardians.

MOSSOP, E. E., M.B., B.S.Lond., M.R.C.S., L.R.C.P.Lond., House Physician to the Hospital for Sick Children, Great Ormond Street, W.C.

RENDALL, PERCY, M.D., M.R.C.S., Divisional Surgeon to the V Division of the Metropolitan Police at Epsom.

TIVY, CECIL B. F., M.B., B.Ch. R.U.I., House Surgeon to the Cork Eye, Ear, and Throat Hospital.

Births.

BALDERSTON.—On Sept. 30th, at 17 Westbourne Road, Forest Hill London, the wife of Robert Balderston, M.B., of a daughter.

GOUGH.—On Sept. 25th, at Compton Martin, near Bristol, Somerset, the wife of Bernard Bradly Gough, M.R.C.S., L.R.C.P.Lond., of a daughter.

PRITCHARD.—On Sept. 27th, at Roden House, Church Road, St. Leonards-on-Sea, the wife of W. Clowes Pritchard, M.R.C.S., L.R.C.P., of a son.

Marriages.

BURGESS—THOMPSON.—On Sept. 28th, at St. Thomas's Cathedral, Bombay, Captain J. Hay Burgess, M.B.Lond., F.R.C.S.Eng., I.M.S., eldest son of the Rev. William Burgess, of Rome, Italy, to Mary Ethel, daughter of the late Thomas Thompson, of Hull and Beverley, E. Yorks, and Mrs. Thompson, Newhaven, Trinity Road, Bridlington.

DE CASTRO—LYNN.—On Sept. 26th, at St. Anselm's Church, Davies Street, Berkeley Square, George de Castro, M.R.C.S.Eng., L.R.C.P. Lond., of 79 Davies Street, London, to Lucy, youngest daughter of the late Palmer Lynn, of Brighton.

HALE—NORTON.—On Sept. 25th, at Rickinghall, Suffolk, Lancelot Hugh Downman Hale, M.R.C.S., L.R.C.P., D.P.H., of Chillington, S. Devon, son of the late Rev. E. Hale, of Eton College, to Harriet, eldest daughter of the late C. T. Norton, Esq., of Hill House, Rickinghall.

WYLIE—HALSEY.—On Sept. 28th, at St. Phillip's Church, Georgetown, British Guiana, Angus Wylie, M.A., M.B., second son of Dr. G. Hamilton Wylie, of Hampstead, to Kate, youngest daughter of D. N. Halsey, Brighton.

Deaths.

BETENSON.—On Sept. 28th, at Sussex Lodge, Newhaven, Mildred Septima, beloved wife of W. B. Betenson, M.R.C.S., L.R.C.P., aged 41.

MARRIOTT.—On Sept. 27th, Sarah Ann, the beloved wife of Charles W. Marriott, M.D., at Aubrey House, Reading, late of Leamington, aged 67.

SPARKE.—On Sept. 26th, at "Tweedale," Brasted, Kent, Ann, wife of George Whitefield Sparke, M.R.C.S., aged 72.

STOKES.—On Sept. 27th, at Howth, Whitley Bland Stokes, M.D., M.R.C.P., F.R.C.S., of 37 Onslow Square, London, youngest son of the late Henry Stokes, Esq., of Askive, Sneem, co. Kerry, aged 42.

STEWART.—On Sept. 28th, at Angelton, Bridgend, Robert S. Stewart, M.D., D.P.H., Superintendent of the Glamorganshire County Asylum.

THOMASON.—On Sept. 24th, at Drybridge House, Hereford, Richard Thomason, M.R.C.S., L.S.A., J.P., aged 77 years.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIII. WEDNESDAY, OCTOBER 10, 1906. No. 15.

NOTES AND COMMENTS.

London Medical Exhibition.

Medical men who missed seeing the London Medical Exhibition last week missed a great event. The Exhibition was twice as large as the first one of its series held last year, and everything that enterprise and forethought could do to make things comfortable and convenient for visitors was done. We publish a special article in another column giving some idea of what was to be seen on the stalls, but the exhibition really was a liberal education in modern medical and surgical methods, and no description could give a sufficiently concrete idea of what was to be seen and learned. The exhibition was got up by the "British and Colonial Druggist," and those who had the opportunity of enjoying their hospitality will be only too glad to accept it again, when it is offered.

"Burkard's Vegetable Compound."

The extraordinary slackness, not only of the public authorities, but of the public themselves, with regard to the danger of patent medicines, was never more strikingly illustrated than by what occurred at an inquest held by Mr. Wynne Baxter at Stepney on October 1st. The subject was a woman, aged 50, who had suffered from indigestion and rheumatism for some time, and who had taken some tablets from a sample packet which had been thrust under the door of the house she worked at. This packet had on the outside an advertisement stating that Burkard's Vegetable Compound would cure pains in the back, tired feeling in the morning, and the usual list of symptoms that one knows so well. There was also the word "poison" on the outside. The advertisement proceeded: "Are you stupid? Are you nervous? Are you losing weight? If so, Burkard's Vegetable Compound will cure you." If one tablet was not enough, two were recommended to be taken. Well, the woman took two tablets, had excessive diarrhœa, and died. The doctor who was called in said that death was due to the result of the tablets, and the Coroner expressed a similar view in more flippant language. "The probability is," said he, "that the tablets finished her off." The jury returned a verdict of "Death from misadventure."

And Public Apathy.

To us as private citizens, apart from our professional knowledge or inclinations, there is something particularly shocking in this tragedy—not only in the fact of death itself, but in the freedom with which "poison" can be put into the homes of the poor, with flamboyant statements as to what it can do for them in their ailments. According to the report we have before us, the case was taken as a kind of farce, the jurymen bandying witticisms and cracking jokes, so that one cannot be altogether surprised that they arrived at the lame and impotent conclusion of "Death by misadventure." Here was a case directly due to the taking of a quack drug, according to both coroner and medical witness, and yet no steps were taken, or seem likely to be taken, to bring home the fact to those who supplied the medicine, in the way that such fact in a properly-governed community should be brought home, and for all we know "Burkard's Vegetable Cure" is still being pushed under the doors of houses where the poor work. There is a very severe punishment for putting strychnine in meat to poison a dog, but the death of human beings from admitted "poison" is regarded as a subject for a joke. Would that Dickens were alive!

"Silly Ass" Novel.

There is a Mr. Domoney, chairman of the Streets Committee of the City of London, who presents such an extreme type of the reactionary that one cannot but rather admire him, as one admires the old-time port-and-Bible country squire who would not hear of letting the railway approach his estate. This Mr. Domoney was much moved to wrath at a recent meeting of the Common Council, at which it was suggested that a communication should be addressed to the Local Government Board relative to the importation and inspection of meat. "What was the matter," he asked, "with the public health?" "What," he proceeded, "was the matter with the ordinary healthy man or healthy woman? All that medical science was doing was to keep a lot of wastrels alive. He was perfectly well now, but did not know whether the meat he ate came from an abattoir or a slaughter-house, and though he ate oysters all through the scare, he never suffered. It was all through some silly ass novel. He hoped the Court would not be led away by doctors or experts of any kind." Mr. Domoney is one of those who are fighting a strong rear-guard action against overwhelming odds. People are beginning to realise that health and happiness for the million are not to be secured by eating and drinking everything retailers like to deposit at the door.

Midwives' Congress.

THE opponents of the registration of midwives have always maintained that their official recognition is certain to create sooner or later an inferior order of medical practitioner. It seems hardly within the probabilities of

human nature that midwives will stop short at midwifery. No such tendency was shown at the recent Congress of Midwives held at Dusseldorf. Associations to the number of 228 and members to the number of 11,501 were represented thereat. The telegraphic reports remark tersely that the speakers did not confine their remarks to obstetrics. Among other subjects they discussed measures for the reduction of infantile mortality, and had much to say on the subject of antiseptics. This extension of professional interest suggests an encroachment upon the medical treatment of infants as part of the midwife's work. The general practitioner has himself to thank for the appearance of the certificated midwife on the scene as one of his many unqualified competitors. Even now by vigorous action he could reduce the midwives to their proper sphere, and at the same time rescue the community from the dangers of further amateur doctoring.

LEADING ARTICLES.

THE TREASURY AND QUACK PROSECUTIONS.

MEDICAL men are perhaps rather too wont to imagine that the only road to the suppression of the bogus medical competition that flourishes on all hands lies through fresh legislation. While it may be true that the evil can never be entirely scotched without a general strengthening of the Medical Acts and of the general powers of the Medical Corporations and the General Medical Council, there is nevertheless a vast amount of machinery in existing laws available for the purpose. An obvious fraud upon the public is punishable as a criminal offence. If a man publishes wilfully false statements in order to procure money he is liable to prosecution for false pretences. If more than one person is involved the offence is treated as a conspiracy to defraud. Now, the published advertisements of many quack medical practitioners, as well as of many quack medicines, claim to cure incurable conditions, and to perform other therapeutic feats that can readily be shown to be impossible. This says nothing of the fact that these pretenders are assuming the ability to perform acts which appertain to competent medical practitioners, whose education and qualifications Parliament has directed and controlled in the most stringent manner possible. The Government of the United Kingdom have neither conferred upon the medical profession the ability to defend itself against the gross competition of unqualified practice, nor, on the other hand, have they taken steps to protect the public against the frauds in question. To a certain extent the general accusation of laxity in protection of the public against gross and notorious frauds may be brought against the Treasury. The Public Prosecutor is a picturesque figure, whose activities are intermittent, unequal, and apparently irresponsible. He prosecutes or does not prosecute offenders against the common welfare in a wayward fashion that robs his office of the confidence it would enjoy if its duties were carried out systematically and on certain clearly-defined principles. So far as the medical profession is concerned, the Public Prosecutor might as well be non-existent; although at the present moment there is far more absolute fraud carried on under medical and semi-medical guises than would occupy the whole time and energies of a second Public Prosecutor. Almost any large journal or magazine taken at random would furnish material for half a dozen prosecutions. Take, for instance, a leather strap, "stuffed with fragrant Eastern herbs," which is warranted to remove wrinkles. Yet the advertisement of such a strap has appeared for years past in the columns of a weekly journal whose special boast is the exposure of frauds upon the public. In spite of their general deplorable laxity, however, of late the Treasury has shown commendable signs of an awakening sense of responsibility in the matter of quack prosecutions. Several notorious electrical and other quacks have been convicted in various parts of the kingdom, and are at the present moment paying the penalty of their misdeeds. We are glad to note that lately, at Brighton, an alleged offence of the kind was brought before the police-court. Two men named Hawkins were charged "that they did unlawfully conspire, combine, confederate, and agree together, by divers false pretences and subtle and fraudulent means and devices, to obtain money and valuable securities from such of His Majesty's liege subjects as should thereafter purchase from them certain powders, and to cheat and defraud them of such monies and valuable securities on January 1st, 1906, and divers subsequent days."

The indictment, reduced to a sentence, charged the men with obtaining money on false pretences. The evidence was to the effect that a world-wide trade was carried on in England, India, Africa, Australia, America, and "various other places." The accused were stated to have traded at several addresses and to have used a number of aliases, among them "Dr. Hawkins, M.D., U.S.A.," "Rev. John Wilson," and "Rev. Thomas Stone." They claimed to cure different diseases by means of powders, and applicants were advised by letter—in some cases, as given in evidence, on the strength of a form for recording the correspondent's symptoms. On analysis certain of the powders sold by accused were said to be composed mainly of bromide of potassium, bicarbonate of soda, and a little quinine. It is obvious that powders of that composition could not have a great monetary value. One of Hamiltons' circulars, however, was said by counsel for the prosecution to have stated that a chemist would charge 28s. for making up these powders, but "our charge is 18s. 9d., which is really cost price." At the time of writing the result of the prosecution has not been announced, and we are therefore unable to do more than sketch briefly the ground of action. Whatever the result may be in this particular case, the fact that the Treasury is at length undertaking such prosecutions should be a matter of congratulation not only to the medical profession, but to all concerned in protecting the public from a serious source of physical and moral degeneracy.

MRS. ALICE ESSERY, wife of a chemist, was last week committed for trial at Plymouth on eight charges of performing illegal operations since last Christmas. Four young women, of whom one was married, gave evidence that they had been to the defendant's house and were there operated upon. Bail was refused.

NOTES ON CURRENT TOPICS.

The Release of Mr. Edalji.

It is officially announced that Mr. George Edalji, who was sentenced three years ago to seven years' penal servitude for cattle maiming, will be released in a few days' time. Readers of the Medical Press and Circular will remember that we presented a memorial to the then Home Secretary, Mr. Akers Douglas, pointing out that if a solicitor did actually commit so brutal and purposeless a crime, it must have necessarily been the outcome of insanity, in which case he should have been sent to Broadmoor instead of Parkhurst. That petition was signed by some of the most eminent lunacy experts in the United Kingdom. An independent petition was also presented appealing for his immediate release on the score of innocence. The present Home Secretary, Mr. Herbert Gladstone, in releasing Mr. Edalji, appears to have endorsed the theory of innocence, which we are glad to approve as the only logical alternative to insanity. The whole occurrence, however, offers a scathing exposure of the weakness of our criminal law, which offers no chance of judicial appeal to a prisoner. In this particular case the evidence from the first was obviously of an untrustworthy nature, and a man has since been convicted of similar offences in the same locality. Mr. Edalji, in any event, will have to pay a terrible price for the defects of our criminal law. He has spent three of the best years of his life among the horrors of penal servitude. He returns to social life a marked man, and deprived of his qualification as a solicitor. He has been released, but his innocence has not been proclaimed. If he had been deemed guilty Mr. Herbert Gladstone would hardly have reduced his sentence by more than half. We congratulate those who signed our petition upon this result. At the same time it is much to be regretted that official reticence permits no public explanation of the weight attached to our arguments. As Mr. Edalji is restored to freedom, and has not gone to Broadmoor, the only possible inference appears to be that he has received the benefit of a tardy recognition of his innocence.

Dr. McAlister on the General Medical Council

Among the many interesting and valuable addresses that have marked the opening of the present winter session, perhaps no single one is more important than that delivered at Manchester University by the President of the General Medical Council. Of that address we publish a full abstract elsewhere in our columns. As might be expected, the discourse was able, eloquent, and learned, but upon the ardent reformer its doctrine must fall with the shock and unpleasantness of a sudden cold douche. When Professor McAlister recently assumed the presidency of the Council it was hoped in many medical quarters that a new era of progress and reform had begun. Judging from his Manchester address, however, he appears to have already fallen deep into the rut of official pessimism. His defence of the Council is based on its constitution, by which its work is defined as the maintenance and regulation of a *Register* of qualified men and the control of medical education. It is the defective constitution that is the main object of unfavourable criticism in the profession. Professor McAlister tells us in one breath that the Councils work is limited, and in the next he hints at its influence with the Privy Council and boasts of how it has acted *ultra vires* in instituting a student *Register*, and in other ways. He fails to inform us, however, why the Council has refused to increase the number of direct representatives, a step whereby that body would be rendered the mouthpiece of medical practitioners instead of medical corporations. Every one knows that the Council has no direct powers to prosecute quacks, but its very being, as shown plainly enough by the President himself, sprang from the desire of government to protect the public. Surely, if it be necessary to "hall-mark" duly qualified medical practitioners in the interests of the community it is no less imperative to punish unqualified pretenders, who are deadly parasites on Society. The latter function, we maintain, is an inevitable corollary of the former. It is not a little discouraging to find the learned President of the Council making so emphatic a declaration of the impotence and disabilities of that body in forwarding the interests of the general practitioner, who, after all, forms the backbone of the profession, and is likely to survive the wreck of selfish corporations and of pessimistic officialism.

Brighton Bumbledom.

If the question were put to a body of medical men, acquainted with the demands of the scientific treatment of disease, whether a town with 150,000 inhabitants required a resident medical officer at its workhouse with 1,400 inmates, there could be no hesitation about the answer. A visiting medical officer, be he never so efficient, is obviously unable to do all that should be done for the proper diagnosis and treatment of the diseases of so large a number of people, together with the proper training and supervision of the nurses, especially when he is engaged in private practice. Not that a visiting medical officer is unnecessary, but it is clear that a staff of two medical men, one resident and one visiting, is the minimum that such an institution needs. A long and heated debate on the proposition that a resident medical officer should be appointed at the Brighton Workhouse took place at the Guardians' meeting last week, and in the result bumbledom won, and the inmates and the nursing are to go on as before. Although some bitter things were said by certain extreme individuals, the Board as a whole were thoroughly satisfied with their present medical officer, who is both diligent and capable, and the question practically resolved itself into whether he should have the assistance he obviously needs. Moreover, it seems that the infirmary cannot become a complete nursing school without a resident officer, and that, therefore, the probationers are placed at a disadvantage. This argument was quite without effect on some of the guardians, who seemed to regard the training of nurses as a kind of new-fashioned luxury strongly to be opposed by enlightened reaction-

aries. The question was not one merely of expense, for the salary of a medical officer could have been saved out of the lower wages acceptable by probationers who wish for full training, but new and modern accommodation would have been a necessity. In a town of the wealth of Brighton this economising in the comfort of the sick and the efficiency of their institutions is not particularly creditable; indeed, it would be easy within the bounds of courtesy to use a stronger, and perhaps truer, adjective.

Educational Grants in Ireland.

From two prominent institutions in Ireland come complaints of the parsimony of the Government in educational matters. Professor Hamilton (President of the Queen's College, Belfast), in his recent report, has again to express regret at the inadequacy of the Treasury grant to the College Equipment Fund. The President, however, adds to his report a list of the various buildings which are in process of construction, and it certainly does not appear from them that the equipment fund has in any way suffered from Government parsimony. This is, however, entirely due to private munificence. The governors of the Royal Veterinary College of Ireland have, we think, deeper grounds for complaint, inasmuch as although the State has provided them with certain buildings and an endowment, it has given them no means of completing the buildings or equipping them properly. At the annual meeting of the College, which took place last week, the President of the Board of Governors—Sir Christopher Nixon—called attention to the present most unsatisfactory state of affairs. There is no question that additional funds must be provided if the work with which the College is charged is to be properly carried out, but we fear that at present the outlook towards Government aid is not hopeful. The fact of the matter is that enormous sums of money are required for educational purposes in Ireland, but too many of those who undoubtedly have educational matters deeply at heart are asking not alone for what is necessary, but also for what must be regarded as luxuries. Proper university education is a necessity—a university in which each man will find his own religion and politics rampant is a luxury. Improved scientific education is a crying need—the learning of Irish is a valuable literary pastime. At present, however, luxuries are so magnified into necessities that any Government must be excused which fails to distinguish between them, and which, being unable to help both, ends by neglecting the more essential.

A Noted Quack.

During the past few years there has been greater attention given than heretofore to the study of the history of medicine, and, naturally, ancillary to it is the study of quackery. The series of sketches of famous quacks at present appearing in the pages of the "Practitioner" is therefore opportune. The current number recalls the career of that prince of mountebanks, John St. John Long. Like many adventurers of his time, he was by birth an Irishman, and being of humble origin, he was dependent on his wits for his living. During early manhood he worked as a painter and drawing-master, first in Louisville, and afterwards in London, where he was employed in a menial capacity in the studio of Sir Thomas Lawrence. His first relation to the art of surgery seems to have been when he was engaged to colour drawings for the teacher of anatomy at one of the London schools. This suggested to him to start in practice as a healer, and having pretended to discover a liniment of great potency, he was not long in attracting enormous numbers of patients. He must have been a man not only of insatiable ambition, but of very marked gifts, since, depending entirely on them, he soon became one of the most petted figures in London society. Among his other inventions was a gigantic inhaler, round which he grouped his patients, each inhaling through a separate tube. This apparatus, indeed, seems to have been strikingly like one introduced during our own time for the treatment of consumption. From the moment of his starting practice in 1827 up to 1831, Long is said to have received over ten thousand a year in fees. In that year a patient died as the result of his too patent liniment, and he was tried for manslaughter and found guilty. The judge fined him £250! Again, within a few months, he was tried for manslaughter, but acquitted. In 1834 he died of consumption, at the age of thirty-six, having retained his extensive practice and his influential friends to the last.

Employment of Women.

Mr. Chamberlain, in the early days of the Tariff Reform movement, used to argue that British trade was so much cut into by that of foreigners that if this country wished to retain any commerce she would, unless his policy were adopted, be forced to cheapen production by abandoning the Factory Acts. Without staying to argue whether that contention is sound or not, it is pertinent to observe that the Factory Acts, which naturally impose a certain burden on the cost of production, are no handicap to trade if all countries have similar labour laws. The duty, then, lies on statesmen so far to come to terms with the representatives of foreign countries as that the conditions of labour shall be the same in all countries. If that be secured each country will be able fairly to exploit its own products to the greatest advantage. This international regulation of factories is, fortunately, what is already happening. An important conference, attended by representatives from the civilised Powers has just been held at Berne, and at it international regulations for the employment of women were laid down. It was agreed that, except under extraordinary conditions, no woman should be allowed to be employed between the hours of 10 p.m. and 5 a.m. in workshops or factories employing more than ten workers. Another agreement was come to among some of the States—namely, Denmark, France, Germany, Holland, Switzerland, Italy, and Luxembourg—that white phosphorus should not be imported, used, or sold, for the manufacture of matches. It is regrettable that Great Britain

did not see its way to join in this benevolent regulation.

A Flutter in the Dove-Cote.

There is an institution, called the Nurse's Hostel, situated in Francis Street, London, W.C., which is theoretically admirable, but whose practical organisation seems far from effective. This hostel was built to provide independent nurses with a refuge whilst waiting for patients, a kind of glorified boarding-house, quite different from the ordinary nursing home. Now it is clear that not only is it more profitable for a competent nurse to work on her own account, but also that the public is likely to be better served when a nurse's engagements depend on her private reputation than when she is merely exploited by the proprietor of a nursing home as a means for earning commission. The chief *raison d'être* for the nursing home is that a medical practitioner knows that he can rely upon getting a nurse in an emergency, whereas if he sends to a nurse in practice for herself he may find her already engaged. But the nursing home which pays its nurses a salary and lives on their earnings clearly does not give the nurse that proportionate share of the profits of her labour to which she is justly entitled. The hotel or common lodging-house system in which nurses live together and pay for what they receive is a far more satisfactory and equitable arrangement. But it is necessary that it should be run on businesslike principles, and the Nurses' Hostel in Francis Street seems to have started inauspiciously. The superintendent gave little satisfaction to the nurses, and the vital department of the telephone seems from accounts to have been seriously at fault. The essence of a nurse's life is that she should be available at a moment's notice, and that correct information as to her whereabouts should be forthcoming when wanted. The nurses naturally rebelled, and we see it stated the managing directoress thought there was a "lack of discipline" in the institution. From what we can gather the nurses would have been exceedingly foolish to have disciplined themselves to the point of putting up with such management, and we trust that an institution with so many admirable points will be sufficiently reorganised to afford all the facilities that its patrons look for.

Medical Morality.

The correspondence on the "Scarcity of Doctors," on which we commented last week, has attracted a good deal of notice, and various causes have been given for the alleged scarcity. Incidentally another and even more important subject has been opened up in connection with this scarcity question—namely, public opinion with regard to medical morality. "M.R.C.S.," writing in the *Standard* of October 2nd, says that a few of the shady things he has been asked to do in practice have been to:

1. Put a false age on a death certificate, so that the friends might get insurance money.
2. Say that a man was sober at the time of an accident, when he had good reason to think he was intoxicated.
3. Sign for total disablement when a man was doing some of his work.
4. Postpone vaccination indefinitely on account of illness when the child was well.
5. Give a certificate of good health for the insurance of a man with chronic disease, liable to terminate fatally at any time.

Is the experience of "M.R.C.S." exceptional? We fear not. There are temptations in every walk of life, of course, and the practice of medicine in dishonourable hands could soon become a quagmire of immorality. On the other hand it is comforting to reflect not only on the high standard of medical morality, but also on the extent to which that standard is recognised by public bodies. Municipalities and offices know that a doctor's certificate is not to be bought for half a guinea or a guinea, and the person who tries to tempt his doctor to lie generally goes away with a flea in his ear.

PERSONAL.

Mr. J. F. Craig, M.B., of Birmingham, has been elected President of the United Kingdom Police Surgeon's Association for 1906-7.

Mr. C. H. Ballance will open the proceedings of the Medical Society of London for 1906-7 on Monday next with a presidential address.

The official announcement has been made of Dr. Diarmid Noel Paton's appointment to the chair of Physiology in the University of Glasgow, in the place of Professor McKendrick, who has resigned.

Mrs. Stephen Ralli has increased the memorial fund to the memory of her late husband, which she devoted to the endowment of a Pathological Laboratory in the Sussex County Hospital, to £20,000, and it is announced that an assistant pathologist will shortly be appointed in that institution.

The opening lecture of the Christmas Session of the London Medical Graduates' College and Polyclinic was delivered by Sir Henry D. Littlejohn, M.D., LL.D., Professor of Medical Jurisprudence in the University of Edinburgh, on Monday, October 1st, 1906, at 5.15 p.m.

Sir William Broadbent will deliver the annual oration of the Brighton and Sussex Medico-Chirurgical Society, at the Royal Pavilion, on Friday the 26th inst., at 3 p.m. The subject of the address is "The Combat with Disease."

The Royal Sanitary Institute.

A Provincial Sessional Meeting of the Institute will be held at the Royal Pavilion, Brighton, on Saturday, October 27th, at 11 a.m., when a discussion will take place on "Co-ordination of Measures against Tuberculosis." The discussion will be opened by Sir William H. Broadbent, Bart., K.C.V.O.., LL.D., M.D., F.R.C.P., to be followed by G. A. Heron, M.D., D.P.H., F.R.C.P., Louis C. Parkes, M.D., D.P.H., M.O.H, Chelsea, John Robertson, M.D., B.Sc., M.O.H., Birmingham, E. C. Seaton, M.D., F.R.C.S., M.O.H., Surrey, C.C., F. R. Walters, M.D., F.R.C.S., W. G. Willoughby, M.D., D.P.H., M.O.H., Eastbourne, and general discussion is invited. Dr. Newsholme will give a short account of local arrangements for the notification of phthisis, and the sanatorium training and treatment of patients.

A CLINICAL LECTURE
ON
THE OPERATIVE TREATMENT OF INTERNAL PILES.

By SIR CHARLES BALL, M.Ch., F.R.C.S.

Hon. Surgeon to His Majesty the King, Regius Professor of Surgery, University of Dublin, Surgeon to Sir Patrick Dun's Hospital.

IN order to satisfactorily operate for the cure of internal piles, and to avoid the unpleasant after-effects we sometimes see, it is necessary to have a clear understanding of the relations and functions of the structures which surround the outlet from the rectum. As pointed out by Ranney and Symington, the anus is not a mere aperture, but, in a condition of rest, is a definite canal about one inch in length, the lower three-quarters of which are covered by thin cuticle, while the upper quarter is covered by mucous membrane; between these is found the muco-cutaneous junction, which is usually somewhat irregular from the presence of the anal valves, and is known as the pectinate line or, formerly, Hilton's white line. The cuticular portion of the anal canal is arranged in vertical folds to permit of the necessary distention, and when the anus is examined with the margin slightly separated, these folds appear as the well-known radiating ridges. Similarly the

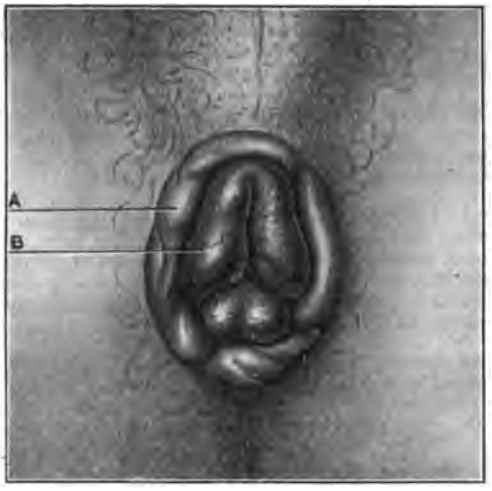

FIG. I.

Prolapsed internal piles. A, Revoluted Cuticular portion of Anal Canal. B, Prolapsed internal piles covered with Mucous Membrane.

mucous portion, likewise for the purpose of permitting distention, is arranged in vertical folds, the columns of Morgagni. In the passage of a motion the first act is the dilation of the anal canal and the obliteration of all these folds; the cuticular portion then becomes revolute so as to expose the pectinate line, or even some of the mucous membrane. When the anal canal closes after the motion has passed, the cutaneous portion involutes and the folds reappear. If piles are present in the mucous portion of the anal canal (the invariable site of internal hæmorrhoids), they protrude during defæcation; the highly vascular and delicate mucous covering is easily abraded, and bleeding takes place. If the piles are small they can be reduced again into the rectum by the combined action of the levator ani and sphincter muscles, but when of considerable size this is impossible, and they have to be pushed up with the fingers within the grasp of the sphincteric apparatus; when still more extensive they prolapse independently of the act of defæcation, and give rise to a great deal of annoyance. If a typical case of prolapsed piles is examined (Fig. 1), we see one or more protuberant masses in the centre covered with bright red, finely granular mucous membrane which bleeds upon but slight provocation, while round the circumference is seen an elevated ridge covered by thin cuticle, and between these the irregularities of the pectinate line are observable; this ridge is really the revoluted cuticular portion of the anal canal, usually somewhat hypertrophied. That this is the true explanation of the outer ring can be readily demonstrated by reducing the internal piles, when the

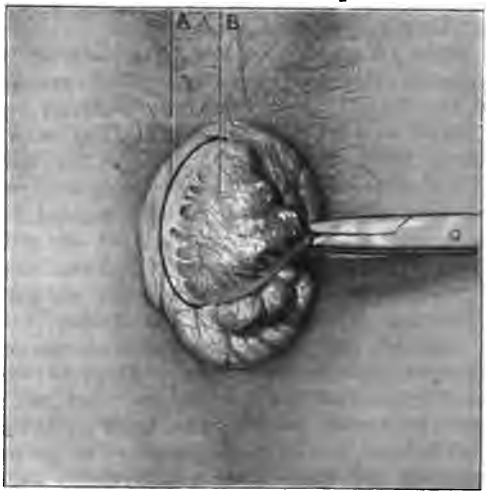

FIG. II.

Showing proper place for incision for removal of internal pile.
A, Revoluted cuticular portion of Anal Canal.
B, Internal pile covered by mucous membrane.
Between A and B the Muco-cutaneous junction with the Anal valves and pouches is well seen.

surrounding ridge can be seen to involute and the anus resumes its normal appearance. Certain variations from the above type are frequently met with. Internal piles which have been subjected to frequent prolapse, possibly for many years, undergo structural changes; they become less vascular, more fibrous, and the mucous covering becomes paler in colour and more like cuticle, while bleeding may have entirely ceased; the circumferential ring also undergoes changes from the formation of thrombotic external piles, and the growth of irregular tags of cuticle.

Choice of Operation.—It is only in the most trivial cases that any plan of treatment short of complete removal is worthy of serious consideration; chemical caustics, electrolysis, and such methods are only applicable to slight vascular excrescences of the mucous membrane where but little new tissue has been formed. If piles of any considerable size are present, some method by which they will be completely removed should be recommended. For this purpose many methods have been employed, excision, ligature, crushing, cautery, &c., while of each of these there are several sub-varieties. Good results have been obtained with all of these, while, on the other hand, the unpleasant sequelæ, hæmorrhage, stricture, incontinence, exposed mucous membrane, and quick recurrence of the disease, may occasionally be observed owing to faulty application of any of the above methods.

The conditions essential to satisfactory operation and prevention of these sequelæ are (1) complete removal of implicated mucous membrane with subjacent pile structure; (2) accurate hæmostasis; (3) avoidance of injury to the muscular coat of the rectum or external sphincter muscle; (4) while removal of redundancy is necessary, great care must be taken to preserve as nearly as possible a normal amount of the cuticular covering of the anal canal. I am satisfied that these conditions can best be fulfilled by the removal of each pile separately by an operation which combines some of the details of excision, crushing and ligature in the one operation. For the past seven years I have adopted this combination almost exclusively.

Method of Operating.—The patient having been anæsthetised to full relaxation of voluntary muscles, is placed in the lithotomy position, and the anus thoroughly dilated by the introduction of the two index fingers or thumbs, by means of which a strain is kept up upon the sphincters until complete relaxation has taken place; this should be done carefully so as to avoid extensive laceration. The piles now become prolapsed and generally more tumid, owing to extravasation of blood into the submucosa, the result of the stretching. An exact estimate is now to be made of the amount of tissue necessary to remove, and a hæmostatic catch forceps applied to each pile or piece of spongy mucous membrane requiring removal; four or five pairs of forceps are thus usually applied, and allowed to hang down in a cluster; in this way there is no danger when afterwards the parts become obscured by blood, of any of the smaller piles being overlooked or forgotten. Taking up one of the catch forceps now, by gentle traction the whole of the enclosed pile is made prominent, and its lateral attachments to the anal canal separated by nipping through with a scissors. Much of the success of the operation depends upon how this dissection is carried out, as already pointed out, prolapsed internal piles are surrounded by a ring formed by revolution of the lower zone of the anal canal, and between this and the piles proper there is found an irregular line which corresponds to the pectinate line or muco-cutaneous junction. If the dissection of the lateral connections of the piles is commenced at the pectinate line, as is commonly recommended, following the original description of Mr. Salmon, it will be found that although the revolution of the lower anal canal can be reduced, at the completion of the operation, it is apt to recur the first time the bowels move and become permanent in the shape of cutaneous tags (external piles), which give a good deal of annoyance and sometimes require a further operation for their removal. If, on the contrary, the dissection is commenced at the outer edge of this cutaneous ring, too much tissue will be removed and possibly an anal stricture will result, or, when healing has taken place, it will be found that a portion of mucous membrane has become permanently everted, which is a great discomfort to the patient from the moist mucous secretion which constantly soils the parts. It is obvious, therefore, that the proper position to commence the dissection is between these two lines, the best results are to be obtained by making a curved incision corresponding to the base of the pile being dealt with, taking care that the greatest convexity of the curve does not involve more than one-third of the cutaneous ring (Fig. 2), while the ends of the curved incision terminate in the mucous membrane at each side of the pile. By blunt dissection the pile is now separated from the external sphincter muscle, which is usually clearly visible, and must on no account be injured. The dissection is carried up the anal canal until the pile remains attached above only by healthy mucous membrane with the vessels coming down into it; this mucous membrane is now to be crushed in a powerful clamp. I prefer one with parallel closing blades; the line of incision is now to be carefully searched, and if any arteries are seen to be bleeding they can be twisted. A curved needle armed with strong silk is now passed through the sub-cutaneous tissue at a point corresponding to the greatest convexity of the incision (Fig. III.), and is next passed

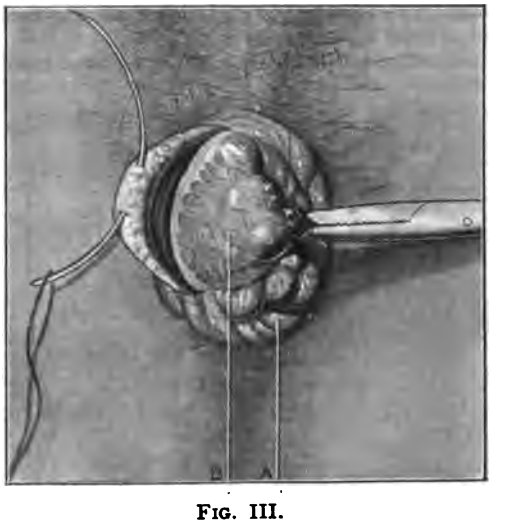

Fig. III.

The way to pass the needle through the subcutaneous tissue at the edge of the flap. The Sphincter muscle is seen deep in the wound, A and B, as before.

through the centre of the crushed mucous membrane forming the pedicle of the pile (Fig. IV.); this ligature is tied first on one side very tightly, thus strangulating one half of the already crushed pedicle, and the ends are then passed round and tied also very tightly on the other side, constricting the entire pedicle and including the half already tied (Fig. V.). The effect of this ligature

is to control the larger blood-vessels going into the pile, while at the same time, owing to its having a sub-cutaneous hold on the revoluted skin of the anal canal, it returns this into place and maintains it in position until union has taken place (Fig. VI.). The use of the crushing clamp is of importance in allowing more accurate application of the ligature and more certain hæmostasis. The pile is now

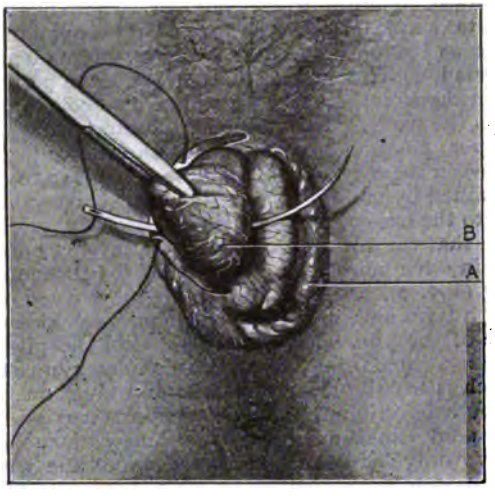

FIG. IV.

Passing the needle through the middle of the crushed pile, A and B, as before.

to be cut away in front of the ligature, but not close enough to endanger slipping, and the remaining piles to which catch forceps were attached at the commencement of the operation treated in the way above described. In the illustrations of this method, for the sake of clearness, the treatment of only a single pile is indicated, but it is to be understood that all are to be treated in like manner.

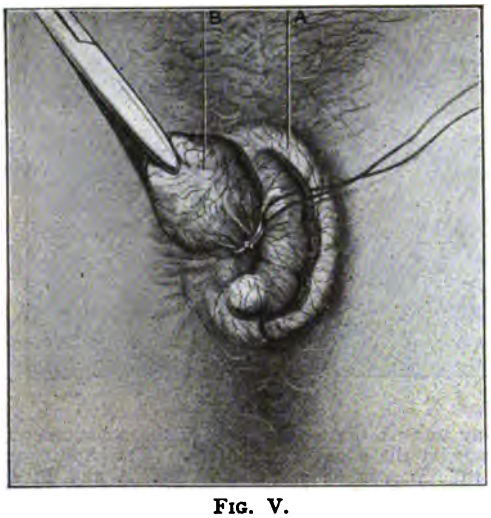

FIG. V.

The ligature completed, A and B, as before.

After-Treatment is usually simple ; the pressure of a gauze pad retained by a T-bandage in position appears to lessen painful spasm of the sphincters. The after-pain is variable. Occasionally trivial, it is frequently severe, requiring morphia for the first day or two. The bowels should be kept confined if possible, until the fourth day, when an aperient should be given. After the bowels have moved, the anus should be washed with weak lysol or other antiseptic, and if the ligature stumps are prolapsed, they should be gently returned within the sphincters. The ligatures should separate during the second week, and in about another week healing is complete. There is usually some inflammatory œdema, which generally subsides without trouble. If the same care is taken to preserve asepsis here as in other parts of the body, abscess or more severe

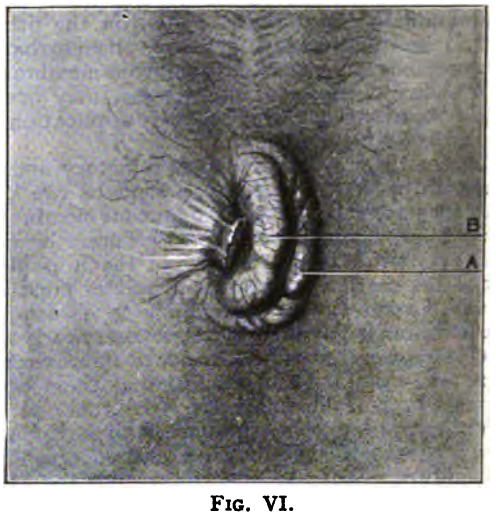

FIG. VI.

Showing stump left after ligatured pile has been cut away, and the way in which the flap of Cutaneous Anal Canal returns to its normal position.

septic complications are extremely rare, notwithstanding the necessary soiling of the wound. If just the right amount of skin has been removed the anus recovers completely its normal appearance and function. There may be a little bleeding the first few times the bowels move, and it is well to warn the patient not to be alarmed about it. Severe bleeding should not arise if the operation has been properly done, but if it should occur, possibly by the slipping of a ligature, it is better at once to give an anæsthetic, dilate the anus, and secure the bleeding point, and not waste time or give unnecessary pain to the patient by plugging or other such means.

NOTE.—*A Clinicol Lecture by a well-known teacher appears in each number of this journal. The lecture for next week's number will be by Francis J. Steward, M.B., M.S.Lond., F.R.C.S.Eng., Assistant Surgeon to and Surgeon in Charge of the Throat Department, Guy's Hospital; Assistant Surgeon Hospital for Sick Children, &c., on "The Surgical Aspects of Tubercular Peritonitis." Lecture delivered at Guy's Hospital, May 25th, 1906.*

AT a luncheon given by the Lord Mayor of Liverpool on Monday last to Professor Ronald Ross, Professor Boyce, and Dr. J. L. Todd, in recognition of the decoration conferred on them by the King of the Belgians for their services in tropical research, Sir Alfred Jones read a letter from King Leopold stating that he had placed the sum of £1,000 at the disposal of the Liverpool School of Tropical Medicine, and holding out the promise of further pecuniary assistance.

ORIGINAL PAPERS.

ABSTRACT OF ADDRESS ON
THE GENERAL MEDICAL COUNCIL: ITS POWERS AND ITS WORK. (a)

By DONALD MacALISTER, M.A., M.D., Cantab., etc.

Linacre Lecturer of Physic, University of Cambridge; President of the General Medical Council of the United Kingdom.

Gentlemen,—To-day I propose to speak, informally but as I trust not loosely, on various matters concerning our common profession and its government with which it behoves us all to be acquainted, and about which many mistakes are made—for want of knowledge.

The General Medical Council has points of interest for students, practitioners, and laymen alike: and my only fear is that I may fail to make them as interesting as they really are. My chief difficulty lies in the misconceptions that exist regarding the Council's powers and its work. I seldom take up either a professional or a non-professional paper that touches upon medical matters without finding evidence of these misconceptions. Sins of commission, more often sins of omission, are freely laid to the Council's account, of which from its very nature and constitution it cannot be otherwise than guiltless. It is scolded for doing what the law says it shall do. It is bitterly reproached for leaving undone what the law gives it neither power nor means to do. It is spoken of at one time as the Parliament of the profession. Yet it has no authority to legislate for anybody, and it cannot make even a by-law for any but its own proceedings. At another time it is scornfully described as a "doctors' trade union." Yet it cannot legally levy an annual subscription, or say a word on the matter of rates of pay, or hours of work, or disputes with employers; it offers no pecuniary benefits or strike pay; and it *can* be sued in the courts like any other corporation. I venture to think that such a "union" would hardly be thought to deserve the name by the energetic organisers of Lancashire and Cheshire trades.

The Council is in fact neither a Parliament for making professional laws nor a Union for protecting professional interests. When the Council was created, nearly 50 years ago, the declared purpose of the Legislature was not to promote the welfare of professional men or professional corporations, it was not to "put down quackery" or even to advance medical science. The object in view was simply the interest of the public. The preamble of the Act of 1858 consists of two lines only: "*Whereas it is expedient that Persons requiring medical aid should be enabled to distinguish qualified from unqualified practitioners: Be it therefore enacted . . .*" The preamble, as you see, recognises two kinds of practioners, the "qualified" and the "unqualified." Up to that time no easily-understood line was drawn between the two, and when the public desired to make a choice, they were frequently at a loss. The Act set up machinery for, as it were, "hall-marking" the qualified practitioner, so that he might easily be recognised when his services were required. But the public were left free then, as they are free now, to seek "medical aid" from the unqualified practitioner if they liked. And the unqualified practitioner was left free then, as he is free now, to practise for gain among those who chose to employ and pay him. He was forbidden under penalties to pretend that he was qualified, by taking a title he did not possess; he might not use the courts for the recovery of his charges; he could not give a valid certificate of death: but except for these and a few other not very inconvenient disabilities he was untouched by the new law.

On the other hand, the "qualified" men, as a set-off to their new legal status and official recognition, were subjected to a new central control, educational and disciplinary. They obtained no monopoly of practice among the public in general. They were afforded no special "protection" against the competition, not always scrupulous or insignificant, of the uncontrolled unqualified practitioner. Indeed, for a time, those of them who were educated and licensed by medical schools and corporations were in a sense exposed to greater competition than before. For at the outset, all who claimed to have practised before a certain date in 1815, whether they had been educated or not, were enrolled among the qualified. In this way a number of elderly practitioners, who had no licence or diploma whatever, were accorded the same legal status as the rest, and practised side by side with them. These, of course, have now disappeared; but their existence must not be forgotten when we are considering the so-called "privileges" of the profession which were conferred in 1858.

The qualified practitioners might fairly have claimed that it would be good for the public, as well as for themselves, if monopoly of practice and protection against the competition of the untrained *had* been conferred upon them. In other countries, and in other parts of the King's Dominions, the restriction of practice to the qualified is with general consent and approval enforced by law. Any unqualified person who habitually and for gain practises or holds himself out as practising any branch of medicine is liable to severe penalties. But in these days of "Christian Science," and "Nature Cures," and "Bile Beans," it requires a good deal of optimism, and some resolute ignoring of the signs of the times, to believe that in this free (and easy) country legislation to that effect is either probable or possible in the near future.

The result, foreseen or unforeseen, of Acts passed since 1858 has been rather the other way. An unqualified *person* can be restrained from using a title, such as "physician" or "dental surgeon," which implies qualification and is reserved by law for qualified men. But if he takes to himself six other persons, as unqualified as himself, and registers the compound individual as a joint-stock company, it is held that, in England at least, he can call himself what he likes. He is no longer a "person," but a corporation—with the usual and highly convenient negation of soul or body. Thus the distinction set up by the Medical Act is blurred by the operation of the Companies Act. The public may well be excused if they think they are dealing with qualified practitioners when they seek advice at the establishments, legally incorporated, of "Dr. Galen Æsculapius Jones, Limited," or "Professor Smith and Co., Consumption Specialists," or "Tooths, Cash Dentists." Strenuous efforts have been made, within and without Parliament, to get this remedied; but so far without much success. The Legislature is in fact very tender towards unqualified practitioners of every kind—so long as they do not presume to practise *law*. The lawyers have seen to it that *that* profession at least is sacred.

I have mentioned that in 1858, when medical men were first officially registered, everyone who claimed to have been in practice some 40 years before was enrolled, even though he held no diploma or other certificate of competency. The vested right even of the unqualified was thus carefully respected. A similar thing happened 20 years later when dentists were enrolled, and to-day the *Dentists' Register* is made up, to the extent of nearly one-half, of men with no other qualification than "in practice before July 22nd, 1878." Four years ago, as the outcome of a bitter cry for the better regulation of midwives, whose want of skill and cleanliness brought suffering and death to countless mothers and infants, the Midwives Act was passed. Again all women went on the roll who applied, and had been in practice for a year—trained and untrained together. Those who did not choose to go on the roll were allowed two or three years more during which they could use the title of midwife, though unenrolled or uncontrolled. And not until 1910 will it be illegal for a woman, who is not enrolled and has no certificate

(a) Delivered at the Victoria University of Manchester on October 2nd, 1906.

of training, to practise for gain that perilous office—perilous I mean to those who place their lives in her hands.

All this care for the unqualified can, I have no doubt, be excused on political and legal grounds. That I am not concerned to deny. I mention it to illustrate the general temper of our lawgivers—and of their constituents also. We all of us in our hearts incline to distrust the rule of the expert, and we rather admire the amateur. Most of us flatter ourselves that in one way or another we are something of amateurs ourselves. It is more than a half-truth to say that England would rather be free, free even to let itself be injured or befooled, than under compulsion to be sober, or healthy, or secure. And so long as this mood prevails I do not see much chance for the Bill that is to "put down quackery" with a strong hand. Parliament may go so far as to "distinguish" the trained from the untrained practitioner: it will then leave you free to make your choice—at your own risk.

The instrument which Parliament set up for the purpose of marking the distinction is called the *Medical Register*. And the making and keeping of this Register is entrusted to the *Medical Council*. On the Register are placed the names of those who have passed certain tests of professional fitness. These are called *Registered Practitioners*, and these alone the law declares to be duly or legally qualified. The Council has to see that the tests of professional fitness actually applied by the Examining Bodies to aspirants for registration are "sufficient." They must ensure that those who pass them possess "the knowledge and skill requisite for the efficient practice of medicine, surgery, and midwifery." The Council has also to see that no registered person who by crime or misconduct has become unworthy of the legal status which registration confers shall remain on the Register. In other words the two great functions which the Council in the public interest discharges are—first to prevent the unfit from gaining access to the Register, and, secondly, to remove the unworthy from it. Except as to a few subsidiary matters such as the preparation of the *Pharmacopœia*, the control of Diplomas in Public Health, the scrutiny of the Midwives' Rules, and the like, all its powers and all its work, in relation to the medical and dental professions, have reference to these two functions. It is a Council of *Education* and a Board of *Registration*.

It is a Council of Education; but it neither teaches nor examines. It cannot lay down a code or curriculum compulsory on all medical students. It cannot inspect a single medical school. Its statutory powers are strictly limited. It can order the visitation and inspection of the various examinations held by Universities and Corporations in the United Kingdom, for the purpose of testing candidates for their respective medical degrees or diplomas. And it can require from these bodies information concerning the course of study, and the age of candidates, which they prescribe. If from the inspection of the examinations, or the information supplied as to the curricula, the Council comes to the conclusion that either are "insufficient," it has no power to disallow them, or to order that they shall be amended. It forwards its report to the body concerned, takes note of any observations the body may make thereon, and if it is still convinced that the training or the test is "insufficient," it brings the question before the Privy Council.

In this and in other matters the Council is in close administrative relation with the Privy Council. If in anything the Medical Council neglects its duty, the Privy Council may formally direct that the duty *shall* be performed, and may in default itself perform it. In the case before us the Privy Council has power to supplement as well as to supersede. It can do what the Medical Council is unable to do. If it sees fit, it can declare that an "insufficient" diploma shall be no longer recognised as legally registrable; and, if circumstances alter, it can rehabilitate the diploma, and make it valid again.

The Medical Council is also a Board of Registration. In fulfilment of this function, partly by the force of necessity, and partly in virtue of the interpretation of the law by the Judges, it has become a Professional Court of Justice, a domestic forum for the trial and determination of grave charges brought against registered practitioners in their professional capacity. By successive judicial decisions it has been laid down that in its procedure the Council, sitting as a tribunal, must as nearly as possible follow the forms and rules customary in other courts. But it has no authority to compel the attendance of witnesses, to administer oaths, or to call for the production of documents. It has only one judgment to give when a charge is proved to its satisfaction—namely, "guilty of infamous conduct in a professional respect"; and only one sentence when judgment is given—namely, "erasure from the Register." From this sentence and judgment, given after proper inquiry and without malice, the High Court of Justice has pronounced that there is no appeal.

All the Act says is: "If any registered medical practitioner shall be convicted in England or Ireland of any Felony or Misdemeanour, or in Scotland of any Crime or Offence, or shall after due Inquiry be judged by the General Council to have been guilty of infamous conduct in any professional respect, the General Council may, if they see fit, direct the Registrar to erase the name of such medical practitioner from the Register." In 1863 the Lord Chief Justice and his colleagues of the Queen's Bench laid it down that this clause "makes the Medical Council sole judges of whether a medical practitioner has been guilty of infamous conduct in a professional respect; and this Court has no more power to review their decision than they would have . . . of determining whether the facts had justified a conviction for felony or misdemeanour under the first branch of the section . . . The Council is the tribunal to whom the Legislature has left the decision, as being the best judges in the matter, and this Court cannot interfere."

In another appeal Lord Justice Bowen declared that, provided "due inquiry" had been made by the Council, "the jurisdiction of the domestic tribunal which has been clothed by the Legislature with the duty of discipline in respect of a great profession, must be left untouched by Courts of Law."

Referring to the language of the Statute, Lord Justice Fry added: "'Inquiry,' and 'judgment,' and 'guilt' are all words which express and which are relevant to a proper form of judicial proceedings, and therefore, although this body proceeds by different rules of evidence from those on which Courts of Law proceed, I cannot for a moment doubt that the Council were proceeding judicially; nor can I help adding that the manner in which the Council has proceeded on this inquiry, as on all other inquiries, shows that the Council are fully aware that they are performing judicial duties, and endeavour evidently to perform them in a very admirable manner."

These and like judgments settled the jurisdiction and the procedure of the Council sitting as a tribunal. The meaning and scope of the statutory verdict of the Council, "guilty of infamous conduct in a professional respect," were given by the definition of the Court of Appeal in 1892: "If it is shown that a medical man, in the pursuit of his profession, has done something with regard to it which would be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency, then it is open to the Council to say that he has been guilty of 'infamous conduct in a professional respect.'"

I have given these important decisions at length for two reasons. They show, in the first place, the position assigned by the law to the Council's judicial inquiries and the range of its jurisdiction. In the second they illustrate the process of legal development by which these words in the Act of 1858—"inquiry," "judged," and "guilty"—have inevitably led the Council to become a court of professional discipline, with duties and powers which were certainly not explicitly set forth in the Statute, if indeed they were implicit in the intentions of the Legislature.

More recently the practice of issuing objectionable advertisements or of employing or sanctioning the employment of canvassers with the object of procuring patients

was brought before the Council in connexion with particular flagrant cases. Each case had to be dealt with on its own merits or demerits. The character of the objectionable advertisements varied; in some cases the canvassing or touting was direct, in others it was carried on through the agency of a club or association or dispensary. Sometimes the case was strenuously fought, in others the accused practitioner preferred to discontinue the practice complained of and submitted himself to the clemency of the Council. Once more when the time was ripe, and the various forms assumed by the mischief were fully apprehended, a "warning notice" was issued as before. This pointed out the public detriment and professional discredit attaching to unworthy methods of attracting practice, and gave notice that practitioners who employed them, or sanctioned their employment, were liable to the penalty of erasure from the Register. A similar notice had already been issued to dentists, as the result of a series of cases duly heard and determined. In this instance the Council had the support of the Court of Appeal, given in a series of important judgments relating to an advertising dentist of some notoriety.

These examples, and I could add to their number, illustrate my statement that even with its apparently limited powers as a Court, and notwithstanding the apparent inadequacy of the Statutes which govern it, the Council does in fact formulate, and by formulation makes explicit, fresh applications of the law to the growing complexity of modern conditions. And, what is more important, in doing so it carries with it the consensus and approval of "professional men of good repute and competency." The average conscience is quickened, and what was once tolerated is in the end repudiated and discountenanced.

The experience of the Council on the judicial side of its work has been singularly paralleled on the educational side. There, too, positive *powers* that are seemingly meagre and inadequate have not prevented it from developing an *influence* which is real and potent.

Its powers only enable it to visit and inspect examinations, and to call for information as to courses of study: it is not authorised to prescribe or to amend either. It cannot itself disallow an "insufficient" curriculum or an "insufficient" test: it can only report its opinion to the Privy Council. These are the limits imposed on its educational action by the terms of the Medical Acts, and at first sight they are narrow enough. But in practice they have proved to be more efficient than they seem in theory; and the "long result of time" has gone far to make them adequate for the purpose. This result has been reached, as in the other case, by a gradual process of evolution, and by the exercise of moral pressure. It is dependent in great measure on three factors—one the constitution of the Council itself, another the loyalty and conscientiousness of the teaching and examining bodies, and the third the publicity of the Council's minutes and proceedings.

Let me say a little, first, about the constitution of the Council. As you all know, the testing of students in medicine, and the granting, to those who pass the test, of medical diplomas and degrees, have been entrusted by the State to Universities and to certain professional Colleges and Societies within the three kingdoms. Some of the Universities are of great antiquity and repute, like Oxford and Cambridge; others are modern and filled with high ambition, like Victoria and Birmingham. The professional Colleges of Physicians and Surgeons are all of considerable age, with traditions of service to the cause of medicine that extend over centuries. Altogether there are now 24 bodies that are legally entitled to test candidates and to confer diplomas. In England, and also in Ireland, two of the bodies, and in Scotland three, have combined for examination purposes to form three Conjoint Boards, one in each division of the Kingdom. But for all other purposes the bodies preserve their autonomy, and make their own regulations. To the fifteen Universities it is probable that a sixteenth, namely the University of Wales, will shortly be added.

Each of the 24 Licensing Bodies, as they are called, appoints a member of the Medical Council. Five members are appointed directly by the Crown, on the advice of the Privy Council, and five members more are appointed by direct election, under a universal suffrage, by the registered practitioners resident within the Kingdom. The total number of members is thus at present 34. Of these, 14 only are required by law to be medical practitioners themselves. The Crown and the Universities may appoint laymen if they like. They have not chosen to do so; but the freedom reserved to them illustrates what I have already remarked on—namely, that Parliament in creating the Council had in mind the safeguarding of general public interests, not of professional or scientific interests. In my own University of Cambridge, the member is elected by the Senate, *more burgensium*, that is, as the members of Parliament are elected. The Senate numbers over 7,000 graduates in all the faculties, and each has his voice and vote. When I was first returned to the Council I had, like better men, to pass through the ordeal of an election contest. The five members directly elected by the practitioners of the three countries were added in 1886. In 1882 a Royal Commission had reported as follows: "While we insist that the reason of the existence of the Medical Council is in the interest of the public, we cannot but recognise the vital interest of the whole Medical Profession in the constitution of that Body. It seems to us highly important that the Profession should have full and complete confidence in the Council, and seeing that the governing Bodies of the Medical Corporations, which now elect members of the Council [and which alone, be it remembered, are required to elect medical men] can hardly be said to represent the great majority of practitioners, we think it advisable to give the general practitioner an effective voice in the Body which will be the principal authority of the Medical Profession. We see no reason to suppose that the members elected by direct representation will be less eminent than those nominated either by the Crown or the [proposed] Divisional Boards" [of the three parts of the Kingdom]. The Commission accordingly recommended that four members should be directly elected, two for England and one each for Scotland and Ireland. The Act, when it came, was framed on a somewhat different basis, and gave three members to England instead of two.

Please observe the main reason alleged for the introduction of the directly elected members: it was "highly important that the Profession should have full and complete confidence in the Council." Exactly the same reason may be assigned for the arrangement, also sanctioned in 1886, by which each one of the Licensing Bodies was granted an effective voice in the counsels of the principal authority. For in their case also it was important that they should have such "full and complete confidence in the Council" as would make them ready to co-operate with it in matters of medical education. The new Act conferred no new coercive powers on the Council. Its numbers were increased, the extent of the qualifying examinations was enlarged and better defined, the scope and method of the inspection to which they were subject were more fully expressed. But the Council, as before, could only in the last resort report to the Privy Council any deficiencies it discoverer. The law, in fact, contemplated that reasonable uniformity and stringency in the existing tests were to be brought about, not by autocratic compulsion, but by common action for a common end. To use the language of a recent Bill, "peaceable persuasion in a reasonable manner" was to be the main motive force entrusted to the Council, so far as Medical Education was concerned. Ardent reformers cried then, and have often cried since, for speedier and more drastic powers. But, after all, is not the method adopted by Parliament characteristically British? "Government with the consent of the governed": "freedom limited only by necessary checks on the abuses which would destroy the freedom and efficiency of others." These are general maxims of our statecraft in regard to other departments of our corporate life. And the State thought well to apply them to the regulation of our profession also.

By its new constitution, then, in which (1) the State

on behalf of the people; (2) the profession itself; and (3) the several bodies which educate, test, and maintain the repute of the profession, possess each of them an effective voice, the Council became better adapted than before for its purpose of regulating the training of medical men. It became in fact a better *Council* of Medical Education. The duty and responsibility of appointing not obedient *delegates* but good *members* were imposed on each of its constituent bodies and sections. Their credit rather than their narrower interest was involved in the selection they made. For the influence wielded by any member of the Council within its walls ultimately depends on his character and capacity as a man among his brethren, and not on the dignity or power of the body which sends him. That influence is instantly weakened and discounted if he comes burdened with a mandate, or hampered by a pledge. He must be a voice, and not merely an echo.

I have said above that the *Constitution* of the Council was a factor in the development of its educational influence. I have given you a sketch of what the Constitution *is*. Let me next consider briefly how it reacts upon the Council's work.

As regards education, the principle sanctioned by the Legislature is that laid down by the Royal Commission of 1882. "It would be a mistake to introduce absolute uniformity into medical education. One great merit of the present system, so far as teaching is concerned, lies in the elasticity which is produced by the variety and number of educational Bodies. Being anxious not in any way to diminish the interest which the teaching Bodies now take in medical education, or to lessen their responsibility in that respect, we desire to leave to them as much initiative as possible. In certain matters of general importance, such as the duration of study, and the age at which a student should be permitted to practise, common regulations ought, we think, to be laid down; but we wish to record our opinion that nothing should be done to weaken the individuality of the Universities and Corporations, or to check emulation between the teaching institutions of the country." In other words, competition between a multiciplicity of teaching Bodies, as such, tends to the advancement of education. The institution which, *cæteris paribus*, affords the most efficient teaching will have the best reputation and be the most resorted to. The interest involved in the competition is the interest of improvement.

In so far, however, as the *primary* tendency of competing examinations might be regarded as downwards, rather than upwards, the State has established a check. It has affirmed the principles (1) that a certain minimum of stringency shall be required; (2) that the minimum shall always be such as to secure efficiency in the practice of the essential branches, and lastly (3) that, to admit of the gradual rise of the minimum with advancing needs and advancing knowledge, the practical definition of it from time to time shall be left to the General Medical Council with the concurrence of the Privy Council.

From the point of view of the Council as a corporate entity, it is also of inestimable advantage that each of its constituent bodies is represented upon it. Its members, in one aspect of their functions, are so many envoys from the Universities and Corporations. Each is in immediate touch with his governing body; he is by hypothesis in good standing and influence there, or he would not have been chosen. While he is an envoy *of* the body, he becomes in turn an envoy of the Council *to* the body. From his own knowledge of the course of the discussion, the arguments used, the examples proposed for imitation, he is in a position to explain and commend the Council's decision to his colleagues at home. He can make clear the scope and bearing of resolutions that are not always, I regret to say, self-explanatory.

The third factor I propose to mention to-day is the publicity of the Council's minutes and reports. About twenty years ago, in a notorious case, an attempt was made to restrain the Council from publishing its proceedings in relation to a penal inquiry. The attempt failed utterly. The "privilege" of the report in question was amply sustained. The Lords Justices of Appeal said: "The report is a report of proceedings which actually took place: proceedings within the jurisdiction of the Council: a report of proceedings where the facts had been ascertained: a *bond-fide* true report without any sinister motive: a report of a matter of public nature: a report of proceedings in which the public are interested, and in respect of which they are entitled to information." "We have come to the conclusion that the publication of these proceedings, being true, accurate, and *bond-fide*, is privileged."

Now if it is for the public advantage that proceedings relating to the character of a particular person should be published, it may well be held that it is still more for the public advantage that reports and proceedings relating to the action of a responsible corporation in the exercise of its public functions should have the like publication. Thus when one of the examinations has been inspected, the Inspector's report, with the remarks of the body concerned, and the remarks of the Examination Committee on both, are presented to the Council, and when duly received, are printed in its public minutes. The report is full and detailed, the strong points and the weak points of the examination are described and commented on, ample materials are furnished whereon to base the judgment of the Inspector, the Committee, and the Council, as to its sufficiency or insufficiency. The whole is discussed in the presence of the public and of the reporters of the various journals, and the decision can thus be criticised with knowledge of its grounds. The net result is certainly beneficial. If a body is commended for some new and valuable feature in its methods, for an examination-experiment which has proved successful, the commendation is public, and the credit of the body is enhanced. The other bodies have the opportunity of learning from the success of the pioneer body, and of adopting the improvements themselves. In this way a virtue is not only praised, it is propagated. It is twice blessed: it blesses the bodies that (thanks to their free initiative) were wise enough to discover or invent it: it blesses also the bodies that offer it the sincere flattery of imitation.

Time fails me to tell you in detail by what curious stages, through what disputes and controversies, along what educational bye-paths, the present arrangement has been reached. It is still transitional, there are still difficulties in the way, it is not yet perfect. But on the whole it is making for progress, for the uplifting of the educational status, and thereby the social status of the profession. And its improvement is fortunately the concern not of the Council only, but of medical men themselves. It is entirely to their credit that so many of them should be eager for a more rapid advance than the Council finds to be practicable. It has to carry a large number of bodies with it; the pace of the march has to take account of the slower as well as of the faster of these; and, as you know now, it has no real power to drive; it can only lead.

Let me make a last confession in closing. The Medical Council as an instrument of professional government is not ideally perfect. But it may be said for it that it did not start *de novo*, full-armed and potent like Minerva from the brow of Jove. Like every British institution it was built on old foundations of tradition and vested right and sacred privilege. It was not a creation but an adaptation. That it had within it, however, the seed of life, the germ of growth and expansion, my informal sketch of some phases in its half-century of history has, I hope, convinced you. Whether its future be one of continual evolution, or of sudden and complete revolution, it has not wholly failed in the task committed to it. The work it has succeeded in accomplishing has not been measured by the scanty powers it originally received.

CASES of fever continue to come into the hospitals of the Metropolitan Asylums Board with increasing rapidity. During Sunday and Saturday 160 fresh patients were removed from their homes, and the latest returns show 4,655 cases under treatment, 3,621 scarlet fever, 877 diphtheria, and 157 enteric fever.

PREDISPOSITION TO DISEASE, OR "MORBID IMMINENCE."

By P. LONDE, M.D.,

Of the Faculty of Medicine of Paris.

[SPECIALLY ABSTRACTED AND TRANSLATED FOR "THE MEDICAL PRESS AND CIRCULAR."]

Diseases, even of sudden onset, do not "break out" without a period of preparation, so to speak, of days, weeks, months, or, it may be, years. This preparatory period may be very protracted in chronic diseases, but it exists also for acute diseases, though it is then of shorter duration. In passing from health to disease we go through a whole series of præ-morbid stages, and a moment arrives when we find ourselves in a state of morbid imminence—the predestined victim of the first accidental cause that may present itself. During this preparatory process there is no disease, properly so called; localisation, at any rate, is still undetermined, and even its nature may remain uncertain. The change in health may not be manifested by any objective, or even subjective, sign, and if there be any prodromata, they are usually very vague.

We must, however, make a distinction between specific and non-specific diseases. For instance, from the moment when the incubation of measles commences, the nature of the disease is established; it will run a definite course, although its form is subject to variations. The evolution of certain other specific diseases, it is true, cannot be forecast with the same precision as in measles; nevertheless, the nature of the disease cannot change the moment the particular microbe has taken possession of the organism. Each microbe has its own peculiar mode of preparing the soil on which it will multiply if left undisturbed by any preventive treatment. The period of morbid imminence or predisposition, however, dates back anterior to infection. Even the receptivity of the subject may vary according to the state of the digestive organs and of the nervous system Disease always surprises the individual under cover of some nervous depression or digestive disturbance—indeed, these two factors are inseparable. The object of this article is, indeed, to demonstrate this fact in respect of non-specific diseases

That disease gains a footing under cover of these nervous and digestive factors is a statement that can hardly be questioned, whatever be the particular form that it assumes—bronchitis, pulmonary congestion, pleurisy, pneumonia, broncho-pneumonia, enteritis, appendicitis, rheumatism, gout, cerebral hæmorrhage, and so on. Diseases such as erysipelas, tuberculosis, and typhoid fever, though markedly less specific than the eruptive fevers, are due to exhaustion of an overworked organism quite as much as to the virulence of the specific microbe. The intrinsic cause dominates here, whereas in the truly specific maladies it cannot be said to exist.

The community of origin of so many very different diseases explains how it is that the physician prescribes repose and diet under so many and apparently opposite conditions. It enables us to understand the morbid equivalents that follow each other in the same subject, apart from diathesis, and it facilitates the treatment of the class of patients, so common in urban practice, who, though they do not conform to any particular pathological state, suffer from functional disturbances, respiratory, vascular, digestive, or nervous, premonitory troubles of a morbid state which will ultimately become defined and localised if rest and diet do not intervene in time.

It follows that the state of morbid imminence is not always latent. It may be manifested by a series of premonitory symptoms which only become prodromal when they group themselves in a characteristic manner. Headache, giddiness, noises in the ears, sleeplessness, diarrhœa, cough, epistaxis, etc., form a prodromal syndrome suggestive of incipient typhoid fever; yet any one of these symptoms separately is commonplace, and may be associated with any sort of affection—infection, auto-intoxication, etc.

There are two categories of symptoms of morbid imminence; some are common to a great many patients, others are peculiar to certain subjects previously suffering from a lesion or a functional disturbance of some standing. We will first of all discuss the common symptoms.

Nervous manifestations are perhaps the earliest of the precursory signs of a morbid state, especially in nervous subjects whose organic consciousness is comparatively highly developed. Side by side with the nervous subjects, by way of contrast, we must place those whose internal sensations are blurred, as in the aged and in alcoholics. It is in the latter especially that the state of morbid imminence remains latent. All forms of pain furnish a valuable indication, the significance of which is in proportion to its previous absence. Pain is a warning; it tells us that the normal equilibrium is disturbed—in short, it is a useful if troublesome symptom. The subject who suffers is better able to defend himself. This is a general law, applicable just as well to a whitlow as to pneumonia, enteritis or what not. Headache constrains us to rest the whole organism, particularly the abdomen, because it impels us to diet ourselves, and although it is often the sign of intoxication or general auto-intoxication, it is not unfrequently the outcome of some sympathetic abdominal trouble. Pain in the head, when unilateral, is often on the same side as the abdominal lesion. Right supra-orbital neuralgia may be associated with hepatic affections (biliary lithiasis), while on the left aide it is associated with disturbance of the stomach or sigmoid flexure.

Among the various kinds of backache, lumbar pain is the most important. We get it under many conditions—spinal meningitis, nephritis, lumbago, enteritis, Addison's disease, fevers, etc. Moreover, like headache, apart from any special indication, it signifies general fatigue, morbid imminence. The same may be said of undue sensitiveness to cold.

In addition to these early sensory troubles, there is a motor trouble that attacks patients long before the outbreak of actual disease—viz., asthenia with associated fatigue. In the psychical domain, somnolence and insomnia, irritability or depression, and especially anxiety, are not less characteristic signs of approaching illness. Some subjects on the eve of an attack of pneumonia, typhoid fever, or other affection, have a sort of presentiment that they are going to be ill. Others are seized with restless activity that makes them try and do several things at a time, as if they knew that this activity was about to be cut short, at any rate for the time being.

Alteration of the facies is a sign that may be associated with asthenia. The eyes become "hollow," and the features are drawn. The "seedy look" is but a rough sketch of the abdominal or influenzal facies. Internal suffering, even if unperceived, is reflected in the face, and even in the look. At the same time the complexion changes, becoming pale or yellow.

After all, these nervous disturbances are but the counterpart of what is going on in the digestive tract. There is arrest or vitiation of the digestive functions, and of the glands in connection therewith. Often the arrest is preceded by pre-morbid activity. Boulimia, for instance, may be met with on the eve of an attack of disease (influenza, articular rheumatism, enteritis, hepatic colic, etc), especially in the new-born. In the same way an exaggerated flow of bile may precede acholia or temporary hypocholia. This stage is followed by anorexia, with furred tongue, constipation, and abdominal distension. These symptoms are defensive acts, just as is the vomiting that may follow. In order to check this pre-morbid auto-intoxication, the organism suspends nutrition and arrests digestion. This is a sort of providential inhibition, because, as disassimilation is not being carried out normally for want of the necessary vital energy, assimilation is inhibited by mechanical control. It is then that the virulence of chance microbes comes into play, taking advantage of the diminished organic resistance. These phenomena are evident at the apertures of entrance to the respiratory and digestive passages for coryza,

sore throat, and stomatitis are due to infections of internal origin.

These are doubtless morbid manifestations that may remain isolated, but very often they merely herald some more deeply-seated affection, the localisation and nature whereof may not stand in any direct relationship to the initial infections. Thus the cough of broncho-tracheitis may prelude enteritis, pericarditis, or nephritis, just as much as a broncho-pneumonia; similarly a sore throat may proclaim the imminence of an outburst of rheumatism, just as much as of influenza or typhoid fever; or digestive disturbances may precede pleurisy, or catarrhal jaundice, or an attack of gout.

Consequent upon the digestive and nervous troubles, the general health suffers, and we get constitutional signs—plethora or anæmia, gain or loss of weight, pallor or congestion. Arterial pressure is modified in the sense that the standard of pressure is seen not to be the same under identical or analogous conditions in a series of subjects—in the subjects of arterio-sclerosis, for instance. In the latter a rise of pressure is essentially a sign of morbid imminence heralding an attack of cardiac hypertension (angina pectoris) or pulmonary (pulmonary œdema) or nasal or cerebral hæmorrhage. Arterial hypertension, like most of these precursory signs, is a defensive reaction, and the same may be said of hyperthermia, which is only an exaggeration of a natural process—in fact, it is in a certain measure a nervous reaction of which the intensity varies quite as much in relation to the individual as to the cause. In acute diseases, cardiac and renal determinations are usually secondary, and it will be sufficient if we point out the early signs that may present themselves—disturbances of cardiac rhythm and modifications in the urine. Tachycardia, brady-cardia, and arhythmia are in some instances premonitory or concomitant symptoms of distant accidents in the digestive area, the kidneys, or the brain.

The urine is the secretion that has been studied most closely in the evolution of disease. Now, in the majority of acute diseases, the results are approximately the same. During the terminal crisis the total excretion is increased, a phenomenon which is a natural corollary of the retention of waste during the attack. The important point to bear in mind in this connection is that the accumulation of waste matter precedes the disease proper, and that the auto-intoxication that results therefrom is the real cause of the disease. In this way we sometimes see a prefebrile discharge of urea, an effort on the part of the organism to avert the threatened infection. Many ill-defined temporary indispositions, characterised by complete inhibition of the digestive functions, accompanied by the asthenia which is its consequence, and the anxiety that is caused by suspension of organic life in any department, are manifested by an increased excretion of urea. What is true of nitrogenous waste holds good in respect of chlorides, and if, in pneumonia or influenza for example, the urine is comparatively poor in chlorides, this is due to the supplementary discharge in the expectoration, which is often rich in saline constituents. It may fairly be assumed that the phenomena which characterise the transition of disease into convalescence are the converse of those which prepare the way for the morbid process. Considered as the ultimate result of a pre-existing auto-intoxication, the disease tends to create a supplementary emunctory or to provoke a phase of extra activity on the part of a normal emunctory.

This view is confirmed by the study of the peculiar symptoms which certain subjects, already the victims of some taint, present during the period of morbid imminence. Persons, for instance, who have a periodical or permanent discharge, remark a modification in this discharge which warns them of the danger. Thenceforth the symptoms will vary according to circumstances, such symptoms being peculiar to this or that category of patients. These special symptoms consist in the exaggeration, suppression, or diminution of an abnormal emunctory already existing, called into existence by a previous malady. Bronchial catarrh, for instance, dries up at the approach of an attack of pneumonia; eczema retrocedes under the influence of asthma; anal fistula ceases to discharge in presence of tuberculosis of the lungs or pleura. In the same way we see the fœtidity of the expectoration or the urine increase on the eve of a fresh outburst of bronchitis or pyelitis, while, on the other hand, a hæmorrhoidal, nasal, uterine, or intestinal hæmorrhage may conjure the morbid evolution at its onset or prevent its appearance altogether.

In this way impending attacks of uræmia or cerebral hæmorrhage, typhoid fever, gout, or hepatic colic may be averted or deferred or arrested. By way of illustration we may mention the case of a young girl with angioma of the upper lip who was never ill, although pale and delicate, simply because she had periodical epistaxis. Preventive recourse to spring-bleeding or the use of setons is understandable, indeed recommendable, because it is unquestionable that a supplementary emunctory by hæmorrhage or suppuration turns aside the morbid proclivity from the deeply-seated organs and dispenses with the necessity for a disease, the object of the latter being precisely the establishment of a supplementary emunctory. This theory is especially applicable to rheumatism. In this case it is the serous membranes of the joints that receive the discharge of the poisons which the organism is endeavouring to get rid of. Salicylate of soda, owing to its action on the liver, checks the formation of these poisons, which, in respect of acute articular rheumatism, appear to be elaborated in the stomach. Disease, then, calls into being an additional eliminatory function intended to get rid of accumulated toxic products accumulated during the stage of morbid imminence.

Just as there are lesions and functional disturbances which ward off other accidents, so also there are diseases which create a state peculiarly favourable to the development of other maladies, thus constituting a series of morbid stages. The chronic enteritis of the new-born is the first stage of rickets; scarlatina places the kidney in a state of morbid imminence, just as acute rheumatism makes us apprehensive of the heart. A child who has suffered from bronchitis will be specially prone to an attack of broncho-pneumonia in the course of an attack of measles or whooping-cough. The gravity of a previous infection, as in cholelithiasis, will be increased in presence of any intercurrent infection. It would be easy to multiply such instances, but this is unnecessary except for the purpose of pointing out that repose and diet are always the necessary conditions of the preventive treatment of complications of diseases. The same means that enable us to avert diseases enable us to prevent their getting worse.

TRANSACTIONS OF SOCIETIES.

CENTRAL MIDWIVES BOARD.

MEETING HELD OCTOBER 4TH, 1906.

Dr. CHAMPNEYS, President, in the Chair.

AT the beginning of this, the Autumn Session, the chief matter brought before the Board was the answer to the Privy Council regarding suggestions made *re* amendments to the Rules as revised by the Board.

With respect to Poor-law Institutions, the answer was returned that the Board did not see its way towards recognising these as training centres.

Dr. CHAMPNEYS thought a certain number of cases essential. The resolutions referring to the number of cases were framed for their own guidance, and were of a tentative nature only. The Board did not wish them stereotyped, and hardly considered they were "Rules" requiring formal approval by the Privy Council.

Dr. Parker Young considered the Poor-law Institutions should be utilized, and less than six cases required.

Miss Paget remarked there was certainly no reason for not using the Institutions save that very frequently there was only one pupil for the teacher.

To the next suggestion—whether midwives should be compelled to notify births within forty-eight hours the Board returned answer that in their opinion the matter was one for legislation and not for a Rule of the Board. Also in answer to a letter from the Secretary of the Royal Commission on the Poor-law and Relief of Distress asking for a witness to give evidence as to the attitude of the Board in recognising such institutions, it was stated that the time was inopportune while the Rules were under revision.

Dr. Hope, M.O.H., Liverpool, wrote concerning the right of a midwife to advertize herself as an herbalist but at the Standing Committee it had been decided the Board possessed no power to interfere.

It was also agreed at the Committee to approve of the Government Maternity Hospital, Madras, as a training centre.

Mr. J. Cromie, L.R.C.P.&S., and Capt. A. E. Weld, R.A.M.C., were approved of as teachers under Rule C. 1 (3). On the Secretary notifying that among other refusals the name of Mr. Arthur Thompson, M.R.C.S., L.R.C.P., figured.

Dr. Parker Young rose to protest, saying Mr. Thompson was Medical Officer to the Newbury Workhouse, and attended all cases. The midwives there were very anxious for a teacher. When the application came up there were only two members present. He felt a great injustice had been done to the midwives in requiring them to come twenty times for lectures over sixteen miles at a 3s. fare. The Board was created to help the women to become competent. He wished, therefore, to move an amendment.

The President, in agreement with an argument often used by Sir William Sinclair, said it was not desirable to multiply teachers and lower standards; that it was understood at the time of decision that the nearest centre was near enough, and they could not establish centres within ten minutes of everyone.

Dr. Parker Young's amendment had no seconder, and therefore was lost.

THE OUT-PATIENTS' ROOM.

METROPOLITAN HOSPITAL.

Tachycardia. Blood-pressure.

By Leonard Williams, M.D., M.R.C.P.

This young man, æt. 24, first came to the Hospital during my absence. I find on his paper that he was then suffering from tachycardia, and that his pulse tension was high. It may be worth while to consider for a moment what we mean by tachycardia, and what we mean by pulse tension, taking the latter first.

Pulse tension, arterial tension, and blood-pressure are all used as synonymous terms. It is a pity that this should be so, but as it is so, we may accept the fact and use them indiscriminately. Now the person who made this note regarding the pulse tension of this patient probably meant his blood-pressure. One would like to know how he arrived at the conclusion which he records that this blood-pressure was high. If he had used an instrument, we may assume that he would have noted the exact measurement of the blood-pressure so recorded. If he did not use an instrument, then his opinion as to the state of the blood-pressure is practically valueless. There are people who, after feeling the pulse with one hand, will make a very definite and confident statement as to the state of the blood-pressure. I have heard a physician chide a student for doing this, and he proceeded to demonstrate to the student the proper way of ascertaining the arterial tension. This was by compressing the pulse with the finger of one hand, while the index finger of the other hand felt for the disappearance of the pulsation. Such a method, I may point out, is valuable in ascertaining the compressibility of the pulse, but you must remember that the compressibility of the pulse is in many cases no gauge whatever of the state of the arterial tension or blood-pressure. Only two days ago I found in a gentleman who came to consult me as compressible a pulse as I have ever felt, and yet his blood-pressure as registered by the Hæmomanometer reached no less than 200 mm. of mercury. Do not assume, therefore, that a compressible pulse necessarily indicates a low blood-pressure. Moreover, when we speak of blood-pressure we ought to distinguish between systolic and diastolic pressure: for, as you know, there is one condition, namely, uncomplicated aortic regurgitation, in which the systolic pressure is high and the diastolic pressure is low. A note, such as we find on this paper, then, to the effect that the pulse tension is high, is absolutely valueless. If you want to study blood-pressure you must use an instrument, for, as Professor Clifford Allbutt has pointed out, it is as futile to talk about blood-pressure without the aid of an instrument, as it is absurd to discuss temperature in the absence of a thermometer.

Now as to the other matter. What is tachycardia? Tachycardia indicates a quick pulse, but, surely, if we sound the pulse of a man who has been running a mile race, and find it beating at the rate of 150 or 160, we should not be justified in describing that person as suffering from tachycardia. To merit such a term the condition of rapid pulsation must be sustained, at least relatively, under varying circumstances. Now this young man, as he stands, has a pulse of 150, but if we lay him down and make some slight pressure upon his abdomen so as to empty his splanchnic vessels, we find that in the course of a few minutes his pulse rate falls to 90. Now that is not a condition which is justifiably described as tachycardia. Real tachycardia you will find exhibited in Graves' Disease. You will find it in commencing loss of compensation in valvular disease of the heart and in many other cardio-vascular conditions. You will find it—and this is a point upon which I should like to insist—you will find it as an early symptom in pulmonary tuberculosis. That is what is known as a "tip," and it is a valuable one. The real tachycardia, that is to say, the increased pulse rate which is not produced by exercise, by posture, or by other conditions known to influence the pulse rate, is very often due to commencing tuberculosis.

Now, if this young man is not suffering from tachycardia, what is the meaning of his increased pulse rate in the upright posture? You may satisfy yourself that his heart is in a perfectly normal condition. It is not enlarged, the sounds are normal in intensity and in rhythm, and there are no murmurs. In the recumbent posture the heart is, as it were, well within its stride. As soon as we get the patient up and walk him about, it seems to labour. Why should it do this? The reason is obvious if you will consider for a moment the factors which commonly influence the pulse rate. The greater the resistance to the blood flow, the more slowly and more powerfully does the heart beat. If you lessen that resistance the number of the beats increases. Now, given the fact that the heart is sound, we must look to the arteries for an explanation of this instability of the pulse rate. If the arteries are tightly contracted, the heart will beat slowly, in most cases at any rate. If, on the other hand, the arteries are dilated, the peripheral resistance to the blood flow is lessened, and a quickened rate is the result. The blood stagnates in the dependent portions of the body, and an insufficient amount of fluid reaches the heart. This I believe to be the state of matters here, and I feel confident that if we give this young man drugs such as strychnine and ergot, which are known to increase the contractility of the peripheral arteries, we shall relieve him of his so-called tachycardia and of the many unpleasant subjective symptoms of which he complains.

OPERATING THEATRES.

ST. THOMAS'S HOSPITAL.

EXPLORATION EIGHT WEEKS AFTER OPERATION FOR APPENDIX ABSCESS.—Mr. EDRED M. CORNER operated on a boy, æt. 10. Whilst the child was being anæsthetised, Mr. Corner made the following remarks:—He said that the case was a very unusual one. Eight weeks ago, the boy was operated upon for an appendix abscess on about the tenth day of the illness. An incision was then made, the right rectus abdominis split, and the peritoneal cavity opened. A tumour at once became obvious, with the intestines pushed to the left. The peritoneal cavity and pelvis could be easily examined, as there were no adhesions. In fact, the tumour was really behind the peritoneum, such as was taught to be common in former years and now is known to be rare. Almost every appendix abscess was, he remarked, primarily intraperitoneal. The peritoneal cavity was carefully packed off with gauze and the abscess drained. Previous to operation, the boy had presented in a marked degree a symptom uncommon in dealing with appendix abscesses. He had a constant and profuse discharge of mucus from a patulous anus! In a small degree, Mr. Corner pointed out, this symptom can be noticed when the abscess is in Douglas' Pouch, and is pointing in the rectum. But in the boy's case the abscess was by the brim of the pelvis and was not pointing. What, then, would have caused the discharge and the patulence of the anus. He believed it could only have been one thing—thrombosis of the superior hæmorrhoidal or rectal vein or veins, as they lie in the mesentery of the lower part of the pelvic colon. This, however, was a very unusual condition. He added that the mucus was sometimes blood-tinged. Suffice it, he said, that the boy was much relieved by the operation. and the mucous discharge diminished, but it did not cease, and neither did the temperature come down. Ten days later, an extra-peritoneal incision was made in the left iliac fossa into a cellulitic mass of subperitoneal tissue. No definite pus was seen. This incision gradually brought the temperature down and stopped the discharge of mucus from the rectum. But the convalescence had been very slow; a Widal reaction was negative. The boy had a septic rash and sore throat resembling scarlet fever, and pains, with a little fluid in his joints. These got well spontaneously. Within the last few days his temperature reached normal, and after being there two days rose to 104°, and he had abdominal pain and diarrhœa, the stools containing blood and pus, not unlike the maroon-coloured pus of a liver abscess. The temperature has now declined, and Mr. Corner was going to examine him under an anæsthetic to ascertain if the source of the pus per rectum could be found. There was no doubt that an abscess cavity had discharged into the bowel, but whether it was a secondary liver abscess, a cæcal abscess, or one due to some necrosis of the bowel associated with the thrombosis, could not be said.

The examination, which was at present carried out under the anæsthetic, revealed nothing, and Mr. Corner said that it only remained to watch the case and to attack whatever might turn up. He thought that this was a most unusual and interesting case of appendicitis associated with an extraperitoneal abscess, pelvic cellulitis, thrombosis of the lower part of the inferior mesenteric vein or veins, surgical scarlet fever, multiple arthritis, and a secondary abscess of unknown situation.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Oct. 7th, 1906.

TREATMENT OF CHRONIC CONSTIPATION.

HABITUAL chronic constipation without any organic lesion is a very common affection, and for that reason, says Prof. Hirtz, is frequently passed in silence. If numbers of persons do not suffer from it, others no less numerous are exposed to all kinds of malaise and troubles, consisting of headache, vertigo, sleeplessness, anorexia, furred tongue, dyspepsia, slight colics, scybalæ (coprostasis).

Generally the patient himself draws the attention of the attendant to the condition of his intestine, whereby diagnosis is rendered easy and the treatment clearly indicated But often enough in general practice the troubles due to coprostasis are found to be somewhat more complicated than those already mentioned, and, if not recognised, might lead to error in the diagnosis.

Besides, constipation does not alone provoke purely functional or mechanical signs, but also general symptoms under the influence of auto-intoxication resulting from the absorption of the noxious products due to fermentation of the intestinal contents.

To these phenomena of constipation are added consequently symptoms of stercoræmia, the patients are poisoned, and this auto-intoxication can be pushed so far as to give rise to most fantastic diagnoses.

Coprostasis is accompanied by abdominal *pain*, variable as to its seat and intensity. All the abdomen may be painful, spontaneously or to palpation, but frequently it is localised in the large intestine. Predominating over the cæcum, it simulates appendicitis, and frequently that diagnosis has been made and an operation discussed. Localised in the right hypochondrium, at the angle of the ascending and the transverse colon it has been mistaken for cholecystitis. Seated in the epigastrium, the pain may be thought due to gastric ulcer or other painful affection of the stomach.

None the less interesting are the *radiating* pains which are felt over the thorax, in the loins and down the limbs, leading one to suppose the existence of intercostal neuralgia, renal affections, or sciatica. When patients complain at the same time of a sensation of fatigue and relative difficulty in walking, the consulting physician should be on the look-out for constipation.

A symptom to which M. Hirtz attaches great importance in coprostasis is the condition of the tongue. The tongue is large, thick, and dirty, covered with a yellowish fur and accompanied with very foul breath, especially in the morning. The patient who suffers from this fœtid breath suffers also from anorexia, accompanied by nausea and sometimes by vomiting, with distension of the stomach after eating.

The fœtid odour is a source of great annoyance, but can be removed by scraping the coating off the tongue twice a day with a hard tooth-brush and using a wash of diluted oxygen water.

Besides these symptoms more directly in relation to the digestive tract, there are others, although indirect, none the less a consequence of chronic constipation, as acne and urticaria.

Psychic phenomena are almost constant in this affection. Sometimes the character becomes irritable, the patients get angry for the slightest cause, everything annoys them, and their society is not agreeable. More frequently they are depressed, taciturn; they are unequal to all work and efforts at distraction. They lose pleasure in living, yet they are in constant fear of dying, or, on the contrary, they entertain ideas of suicide.

The most striking symptom of auto-intoxication is *emaciation*. Frequently a doctor is consulted by persons who have lost all their strength, have become

anæmic and grown thin in very notable proportions—15, 20, 30 pounds, or more. At first sight these persons would seem to be suffering from some cancerous affection or latent pulmonary tuberculosis, whereas they only require intelligent treatment of their chronic constipation to regain their usual health and vigour. A last symptom of coprostasis is *fever*, which is generally intermittent, and varies between 100° and 102°.

In the treatment of chronic constipation, M. Hirtz excludes all drastic purgatives, which are dangerous, and prescribes oils, castor oil or olive oil, with large enemas (one or two quarts) with luke-warm boiled water.

Attention should be paid to the alimentary régime. Meat, eggs, milk, cabbage, should be forbidden for a time and replaced by farinaceous foods, mashed potatoes, and a few green vegetables. When the health of the patients admits it, they might have recourse to the warm douche, and if their social condition afforded it, they might complete their cure by a visit to Chatel-Guyon.

GERMANY.

Berlin, Oct. 7th, 1906.

The *Deutsche Med. Zeitung*, No. 76, contains a reference to an article by Dr. L. von Aldou on

The Digestion of Fat in the Stomach.

The investigations were carried out by a careful analysis of a portion of the contents of the stomach taken an hour after the ingestion of an Ewald-Boas test breakfast. The whole acidity, free hydrochloric acid, the quantity of pepsin and the units of ferments were accurately calculated. These investigations show that the fat-splitting properties of human gastric juice was really still to be determined. The degrees of fat-splitting showed essential differences, whilst at the same time, no explanation of the reason for the difference could be ascertained.

The author felt justified on the basis of his experiments only in a simple statement of facts that smaller or larger quantities of emulsion are obtained; but these examinations do not justify any further conclusions. It is very unlikely—if a fat-splitting ferment really exists in the stomach—that this takes place quite independently of the other factors. The fat-splitting brought about by the author and his assistant was really not the work of a ferment, but a result of bacterial activity was not proved, but considering the great difference observed and want of any explanation of them, this possibility must be kept in reserve.

The justification of this standpoint was shown clinically by annual experiments carried out in Kunkel's Würzburg Institute. The fat-splitting of kittens fed freely with fat was so small when killed after a certain time that the whole process could be said to be free of both free acid and bacteria. At present we are not justified in speaking of any digestion of fat taking place in the stomach as being of a fermentative nature.

Prof. Umber and Dr. Th. Brugsch, of the City Hospital, Altona, discussed.

The Digestion of Fat in the Intestinal Canal with Special Reference to Fat-Splitting,

in the *Arch. f. Experim. Pathol.*, 55, 2 and 4.

The fermentative fat-splitting in the alimentary canal is by no means all cared for by the pancreas. Besides the fat-splitting ferment of the stomach (unquestioned by these authors) and the insignificant bacterial splitting which in the absence of intestinal juice in the bowel, in consequence of isolated pancreatic disease, cannot prevent the normal splitting up of fats, there is still another series of organs (liver, spleen, intestines, bile and blood) that are so important that they can almost equal the fat-splitting power of the pancreas. All these juices stand in many-sided and interchanging relation to each other, sometimes accelerating sometimes retarding, varying according to the kind and stage of digestion.

In this way it is explicable how in isolated pancreatic disease the fat-splitting may go on to a completely normal extent. Where, however, a portion of the intestinal tract becomes implicated in the disease of the pancreas (to any considerable extent) the fat-splitting powers of the intestinal canal must suffer.

Peritoneal Absorption.

A great deal has been written on this subject, and it has again been brought to notice by experiments made by Dr. K. Freytag, of the Royal Chir. Univ. Klinik, Bonn, the results of which have been published in the *Arch. f. Pathol. v. Pharm.*, 55, 4 and 5. The results were the following:—The resorption or the excretion of a solution of milk sugar did not run parallel to one of potassium iodide, the first being all excreted in at least twelve hours, whilst in the case of the iodide a positive reaction was obtained even at the end of twenty-four hours.

In severe and moderately severe cases of peritonitis resorption is slowed from the first or second hour.

In mild cases the absorption was accelerated during the first two hours.

Adrenaline retarded the absorption of a solution of milk sugar. In inflammation running a chronic course as well as in the case of abscess cavities, the absorption is slowed, but only slightly so.

A similar subject is discussed in the *Zeitsch. f. Chir.*, 82, 3 and 4, by Dr. P. Glimm, of Greifswald. His conclusions after investigation are as follows:—The absorption of substances soluble in water and probably also corpuscular elements, is accelerated by bacterial infection.

The view that absorption in advanced peritonitis that leads to death is impeded is not correct.

Olive and other oils check in a high degree absorption in peritonitis caused by bacterium coli, and the oils are well borne by the peritoneum.

The checking and slowing of absorption of bacterial fluid acts favourably on the course of the disease.

The origination of a peritonitis is not favoured by a check to absorption of fluid, but by an acceleration of it.

The investigator was well aware that a purulent peritonitis such as is met with in the human subject, could not be set up in animals for experimental purposes, but it is only through experiment that we can learn to understand the changes that take place during an attack of peritonitis. He is of opinion that the injection of olive oil would have an effect on the human subject, and in a desperate case after other remedies have failed, he would not hesitate to inject 130 ccm. of 1 per cent. oily solution of camphor. Chronic abscesses from which bacterial absorption takes place for weeks together might be treated in a similar way. No harm can be done, but, on the contrary, possibly much good. The writer, in the present state of our knowledge, would not dream of prophylactic oil injection. He also suggests the possibility of the injection of oil also being useful in joint suppuration and collection of pus.

AUSTRIA.

Vienna, Oct. 7th, 1906.

Aortic Valvular Disease and Syphilis.

Ryba, at the Prague meeting, related his experience in the exhaustive examination of 65 cases of aortic insufficiency. The ages of these varied from 30 to 40 years of age, but the most singular combination was the history of syphilis in every case, and the constant absence of rheumatism, chorea, angina, &c. Eight of these cases were examined in the *post-mortem* room, and were pathologically found to be chronic aortitis associated with what we recognise as gummatous deposits. The first changes appeared to be dilatation of the ascending aorta, and consequently to insufficiency of the valve; in very few cases were the valves sclerotic themselves. The first symptoms appeared about fifteen to seventeen years after infection with the syphilitic virus. It might also be added that

18 of these cases suffered from oculo pupillary symptoms; 6 from tabes, and the others from other severe psychical phenomena.

Thomayer remarked that his experience in these cases was that they were first attacked with angina pectoris, and later with the symptoms of aortic insufficiency. The cause of the early appearance of the angina was probably due to the structural changes in the aorta followed by sclerosis and degenerative changes in the vagus.

Sambesger thought the practical result of this investigation should lead us to treat such cases with anti-syphilitic remedies in the hope of modifying a chronic intermitting virus.

ATROPHIA SYMPTOMATICA.

Peta reported two cases of symptomatic atrophy arising from intestinal catarrh. The first was a child æt. 9 months, and weighing 5½ kilos, or 12.1 lbs.; the second, æt. 5, weighed 7½ kilos, or 16 lbs. By a perfect change of diet and careful nursing both of these children were restored to health. The first step was to abandon milk at once and adopt one of the many foods on the market at the present time as a substitute. Along with this, Rejtarek's Malto bath is an invaluable adjunct in the treatment.

EXTIRPATION OF THE BLADDER.

Pitha recorded his experience in a woman, æt. 70, who suffered from incontinence owing to cancer in the viscus. She suffered great pain, associated with hæmoptysis, which induced him to operate. He removed the bladder and attached both ureters to the wall of the vagina; but no urine came from either of the ureters in their new position, and the patient died next day.

At the *post-mortem*, the right kidney was found to be entirely destroyed by tubercle, and the left greatly enlarged, which pressed on the ureter below and caused a damming back of the urine in the pelvis of the kidney with dilatation and uronephrosis. The papillæ were flattened, but no abscess was found, while the urine was so decomposed and thick that it would not pass along the ureter. It is interesting to note that no trace of tubercle could be found in the left kidney.

MYXŒDEMA.

Sieber related the history of a case of myxœdema he treated with the thyroid extract with a little improvement. The œdema began in the eyelids and extended over the face. Next the hands and fingers began to swell, perspiration cease, hair to fall out, hearing grow dull, and the mind to become weak. The tongue at the present time is thick and the speech indistinct. The thyroid gland is very small, skin dry, while the hands and feet are greatly swollen; temperature 36° Cent., and pulse 72.

CHOLELITHIASIS.

Peigerova next discussed the ætiology of gall-stones, and quoted two series of cases he prepared in his investigations. His first comprised 14 cases of females, where the disease affec ed different phases of life, but particularly during the gravid period.

The second series, 24 cases, were all associated with the excess of saccharine matter in the dietary, which he considered the incontrovertible foundation of cholelithiasis.

ITALY.

Levantine Riviera, October 7th, 1906.

WHILE the names of health and pleasure resorts on the French Riviera are, to most people, as familiar as "household words," and even places on the Italian portion of the seaboard, which extends from Ventimiglia to Genoa, are fairly well known, yet, strange to say, though many hundreds of English travellers pass every year along the eastern Italian Riviera on their way to or from central Italy, this picturesque coast, with its interesting inhabitants, remained until lately very much as a sealed book to the majority. Correctly, this Riviera is considered to extend from Genoa, southwards to Leghorn, but that portion from Genoa to Spezia concerns us mostly. Here there are various resorts well worthy of attention, all easy of access, some already much frequented by travellers and invalids, who have discovered the beauty of this coast, who are attracted rather than otherwise by its quieter social atmosphere, and who, if they find some of the resorts a little more primitive than those on the French Riviera, find also the advantage that they are less expensive. Besides this, there are climatic differences which to many people are definitely advantageous.

Of all the stations on this sea front, fifty-six miles in extent, those at either end are the most important. Genoa is, of course, well known to every traveller, but it is not a favourite with invalids, apt as it is to be cold and draughty. Spezia, on the other hand, has for many years been something of a health resort, much frequented by English travellers who have been in the habit of making a short stay there *en route* for Florence or Rome, or of remaining for a longer time.

The other places immediately situated between Genoa and Spezia were, until recently, very imperfectly known, and are still so, though Rapallo, which has increased somewhat rapidly, is an exception, the number of its English visitors now being considerable. Taken in order from Genoa southwards, the chief resorts between that "city of palaces" and Spezia are Nervi, Rapallo, St. Margherita, Portofino, Sestri Levante and Levanto. The purpose of this article is not so much to specify the relative advantages of these places individually but collectively in their climatic conditions, and these, broadly speaking, do not differ greatly from the other and better-known resorts on the western Riviera. Both Rivieras are characterised by the proximity of mountains and sea, with a narrow band of land intervening, but extending inland here and there where the mountains are encroached upon by valleys which terminate seawards in small but picturesque bays, and where for the most part are the small towns which are developing into health resorts.

The mountains facing towards the mid-day sun form a barrier against the colder winds, and absorb much heat from the sun's rays, which heat they throw off again during the night, so that the atmosphere, warmed also by radiations from the surface of the sea becomes of an average temperature about ten degrees higher than in England. At the same time there are many more sunny days and fewer cloudy ones; while associated with this condition is the fact that there are constant alternating currents of air, between sea and mountains, resulting in a mild but fairly bracing climate, causing a slight stimulation and increase of bodily vigour.

Along the east coast there is undoubtedly more rain than westwards. Nevertheless, the relative humidity is said not to be high, and against the fact of a greater rainfall may be reckoned a more luxurious vegetation, less dust on the roads, and a softer atmosphere, which is fully appreciated by people who cannot sleep in too dry and exciting an air, also by invalids with bronchitic and asthmatic troubles; such people also rejoice in the absence of the cutting mistral, which is not experienced on this coast.

It should be remembered that here, as on many parts of the Mediterranean shore, the contrast between sunshine and shade is great, and the cooling of the air at sunset necessitates continual watchfulness, so that invalids should never be without easy access to warm wraps; and those who pass the winter in the Riviera should take with them warm clothing, since if a north wind blow—even though its force be broken by the Apennines—and snow fall upon the mountain sides, the temperature even on the seashore will be considerably lowered.

It is scarcely necessary to indicate the complaints which are likely to receive benefit from a stay on this coast, and from climatic conditions such as those which have been described. It is evident that all those requiring a mild tonic treatment, with a combination of mountain and sea air, the proximity of pine woods, a temperate climate, and non-irritating atmosphere, will probably grow stronger and better during their

sojourn in the eastern Riviera, but pulmonary tuberculosis is better combated at a greater altitude; moreover, your Italian hotel proprietor, as a rule, looks askance at sufferers of this type, and gives them but a poor welcome.

It should be mentioned that the season extends from October or November till June, the best months being April and May.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

BELFAST.

The Health of the City, and the Medical Officer of Health.—As reported in this column last week, the much discussed appointment of a Medical Officer of Health for the city was made on October 1st, Dr. Bailie being the successful candidate. This appointment was first suggested as probable in this column nearly a year ago, when Dr. Bailie retired from the Corporation, with, as we then suggested, the object of qualifying for the post by the necessary six months' absence from that body. It was generally recognised that a job was contemplated, and strenuous opposition was raised by the Citizens' Association and other public bodies. Dr. Bailie was the nominee of the so-called "old gang" in the Corporation, a party in which jerry-builders and property owners and their hangers-on are prominent. The chairman of the Public Health Committee must be held largely accountable. He is an elderly medical man of private means, who finds his amusement in the duties of this office, but unfortunately the city has to pay dearly for his entertainment, the death-rate being among the highest in the United Kingdom. If he had taken a strong line in opposition to this appointment it could never have been made, but he allowed himself to be used by the "old gang" to promote their own private ends.

The matter is by no means done with, however. A strongly worded manifesto has been published by the Citizens' Association, and efforts are to be made to procure a Royal Commission to inquire into the health of the city, and questions connected with it. Though it is doubtful if the Local Government Board has any power to veto the appointment when their regulations have been complied with, a strong protest has been lodged with them against it. The manifesto gives again the names and full qualifications of the six candidates for the post put on the short list, all of whom appeared before the Corporation on October 1st. It then goes on to say: "Of these the final vote was cast in favour of Dr. Bailie, and the following facts are especially to be noted:—(1) That of the six candidates, five had previous expert experience as public medical officers of health. (2) That the same five had medical degrees of more or less distinction from the universities. (3) That the sixth and elected candidate, had no previous experience as a medical officer of health, and that he had no medical degrees from a university." The voting is then analysed, and the thirty-two men who supported Dr. Bailie are named, with a note as to those who retire from the Council next January. There is no doubt that the names will be remembered when the elections come on.

The Typhoid Outbreak.—Some fifty-five cases of typhoid have now been notified in the Windsor district of the city, and several deaths have occurred. The district is one of the best in the city, and many of the cases are in isolated houses standing in their own grounds. The sanitary authorities have stated that the outbreak is not due to defective sanitation, but to other causes. Concerning these other causes, however, they maintain a discreet silence. It is commonly reported that they are due to contaminated milk from one dairy, and if this turns out to be the case it will greatly strengthen the hands of those who have for years advocated the proper inspection of the dairies supplying the city with milk.

Supposed beri-beri in Belfast.—A Norwegian barque arrived in Belfast last week from Bangkok, with a cargo of teak-wood. It is reported that two of the crew developed beri-beri on the voyage, and were landed at one of the Cape Verde Islands. Another case of sickness developed later and was removed to hospital in Belfast, but considerable reticence is maintained concerning it.

SCOTLAND.

OPENING OF THE NEW BANGOUR VILLAGE ASYLUM.

This Asylum, which has been erected by the Edinburgh Lunacy Board at a cost of nearly £300,000, was formally opened by Lord Rosebery on October 3rd. During the eight years it has been in process of formation the asylum has received a great deal of criticism chiefly with respect to cost of construction. When, in 1897, the city of Edinburgh was formed into a lunacy district, it had to face the problem of accommodating nearly 1,000 lunatics who had hitherto been maintained in various asylums, particularly Morningside. Chiefly on the recommendation of the late Sir John Sibbald, the District Board resolved to adopt the village system for their new asylum, and, having purchased the Bangour estate of 900 acres, they invited competitive plans, of which those of Mr. Hippolyte Blanc, R.S.A., were ultimately adopted. In the village system the institution is composed of a series of detached buildings distributed over the ground without formality, everything suggestive of restraint being avoided. After the plans had been adopted they were severely criticised on the ground that they involved an unduly lavish expenditure on ornamentation, and finally the architect had to strip his elevations of practically all decorative adornment, and to rely for architectural effect on variations in the form of the buildings and variety in the external treatment of roofs and walls. Much thought has been expended on ensuring that the ordinary fittings of the houses are so constructed that the patients cannot employ them to do themselves harm. The windows, for instance, are opened and closed by a hidden mechanism, out of reach of the inmates. The main divisions of the village are the medical section at the east end of the estate, and the industrial section, at the west. Placed centrally are the laundry, kitchen, stores, bakery, engines, electric plant, and wood and iron workshops. In the medical section there is an administrative block, with admission wards in which the patients are kept for some days on entering the asylum before being finally allotted to some particular department. In this section, too, are a hospital for bedridden patients, and buildings for acute cases, as well as a nurses' home. In the western section are the industrial homes, with a recreation hall; these are at present designed for 750 patients, while the administration is on such a scale that the full number of 1,000 can readily be catered for when necessary. At the extreme west of the estate there is a farm with a completely-equipped steading, worked by the male patients. The village asylum is thus quite self-contained, having its own reservoir and water supply, a complete system of drainage in duplicate with terminal septic tanks, an electric light and telephone installation, fire hydrants, and a branch line of railway of its own. At present there are about 400 patients at Bangour, and they are coming on at the rate of about thirty a week from the other institutions in which they have hithero been boarded.

Lord Rosebery was received at the entrance to the administrative block by Bailie Richard Clark, the chairman of the board, and having formally opened the building, made a tour of inspection, accompanied by the medical superintendent, matron, and other officials. After the ceremony the company gathered for luncheon, and the toast of the Bangour village was proposed by Lord Rosebery. His lordship in no way belied the reputation he deservedly possesses as a graceful orator, yet many who heard him would fain have noted a

less pessimistic vein in his words. There was little prospect, he said, that his wish to see Bangour village more deserted than Goldsmith's hamlet would ever be consummated in the face of lunacy statistics of the past half century, which showed an increase of certifiable lunatics amounting to 231 per cent., while the general population had increased only at the rate of 75 per cent. In Ireland the contrast is even greater, because while there is an enormous emigration of able-bodied people from Ireland, there is an increase at the same time of lunacy, which seems to point to the fact so poignant to us that the best men are leaving the country, and only a large percentage of the weaklings, the helpless, and the insane remain behind. Again, speaking of the expenditure on lunacy, he found that the capital invested in asylums in the United Kingdom amounted to 24½ millions, and the annual expenditure on lunatics to 3½ millions. This money is paid by the nation, not for those from whom it can have any hope in the future, but for those who represent sheer waste and sheer decay. It is for this we build these sepulchres of living humanity, these tombs of the intellectually dead. As to a suggested remedy, it is no use thinking of suppressing marriage among these hereditarily tainted, nor had he much hope from the checking of alcoholism. He believed we could only do much by teaching a higher and better system of life, by showing people that their homes are better worth cultivating and inhabiting than any stray place they may care to visit; thus would there be a great reduction of the strain on the nerves which must inevitably be a cause of insanity. It is to be feared that Lord Rosebery has somewhat overlooked the aspect of an asylum which is most prominent to the medical mind—that it is primarily a place of cure. In his judgment the modern asylum seems solely to be a place of detention—humane and bereft so far as may be of the fetters and barred doors of the prison—but a prison none the less, a "sepulchre of humanity, a tomb." This conception doubtless it was which led him in the opening passage of his speech to express the hope that if any new asylum for the treatment of incipient insanity were proposed it would be carried out on a limited tentative scale, so as not to add to the enormous lunacy expenditure which presses on the country. Lord Rosebery's speech evoked a protest from Dr. Clouston in the form of a letter to the *Scotsman* a day or two later, in which the curative side of the modern asylum was emphasised.

LETTERS TO THE EDITOR.

THE AWAKENING OF THE GENERAL PRACTITIONER.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—If the general practitioner is to find professional salvation, he must find it for himself; and it is certain that he can if he will. It is possible that if he rouse himself he may get help from the minority in the profession who at present show almost complete indifference to his condition. It is possible that the successful consultants and specialists, and the men who are engaged in purely scientific work, and also those holding appointments, civil and military, under Government, may join hands with those who start a movement to promote medical law reform; but the movement evidently can be vigorously started and carried on by those only whose interests are most involved. Medical practitioners are the most highly educated and the best equipped for their work among professions. The State exacts this high standard, and in return confers no privilege whatever. In restricting its public appointments to qualified men, it merely safeguards its own interests. It can be demonstrated that protection of the profession by preventing practice by unqualified fraudulent pretenders would confer vastly greater benefits upon the people than upon medical men, and it can be as easily shown that a like effect would be produced by putting a check upon the traffic in quack medicines. The question is, How can the case be properly proved? Hardly, I think, by any other means than that suggested in your columns, namely, a Royal Commission. The lay press, including journals ostensibly devoted to exposure of humbug and fraud, are, as you have shown, against us. They are biassed by the fact that at least a million sterling is annually disbursed among them for quack advertisements. The British Medical Association, with its 20,000 members, forms, as I have before pointed out, merely a co-operative society for the publication of a cheap medical paper. It has done nothing, and seems indisposed to do anything, to improve the lot of the bulk of its subscribers. If these—the general practitioners—unanimously made the demand, it is possible that the forces and resources of the Association might be diverted into the desired direction. Nothing can be done there or elsewhere until the practitioners have united and prepared to make their voices heard with no uncertain sound. THE MEDICAL PRESS AND CIRCULAR is giving them the opportunity to do these things. Let us hope they will avail themselves of it.

I am, Sir, yours truly,

AN AWAKENED "G.P."

October 4th, 1906. Croydon.

THE DECLINING BIRTH-RATE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Mr. Clement Sers repeats statements, but does not carry this question much further. He mistakes the British Isles for the British Empire, in which there is room for our surplus population for the next five hundred years. The whole empire contains at present only 55,000,000 of people of European blood. Germany has 62,000,000 in the Fatherland alone. She or some other equally virile race will have our oversea possessions in time if we do not people them ourselves. A few decades of the present decline in the birth-rate will place us in the position of France. Mr. Clement Sers would do well to read what leading French writers think of the position of their race—physically, morally, and materially—and of the causation of the decadence. If we are to be saved from a similar fate, the conscience of the people will need speedily rousing. By the term "well bred," I of course implied the scientific, not the social meaning of the term We can by known methods ensure the good breeding of the great bulk of our increase, and by proper organisation find place for them among their kith and kin beyond the seas, if there be not enough room for them at home.

I am, Sir, yours truly,

AN OBSCURE PRACTITIONER.

October 4th, 1906.

THE GENERAL MEDICAL COUNCIL ELECTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The time is rapidly approaching when the registered practitioners of England and Wales will again be called upon to exercise the privileges of electing three of their number to represent them in the General Medical Council. I shall esteem it a favour if you will permit me to state through your columns that it is my intention to again offer myself as a candidate for re-election. During the ten years I have had the honour of a seat in the Council Chamber as a Direct Representative I have done my utmost to promote the cause of medical reform, and to advance the best interests of the profession as a whole. I am led to believe that I have discharged the duties to the satisfaction of the profession generally from the fact that in addition to receiving during the last few months numerous renewed promises of support from medical men in all parts of the country, I have received official intimation that resolutions in favour of my candidature have been passed by the following among other important organisations, namely: the Society of Members of the Royal College of Surgeons of England, the Association of Physicians and Surgeons of the Society of Apothecaries of London, the Midland General Practitioners' Union, and the Incorporated Medical Practitioners' Association. In conclusion, permit me to express my best thanks to those who have assisted me by their

support at former elections, and to say that if re-elected, I shall, as hitherto, endeavour to improve the conditions of medical practice, and to uphold the honour and dignity of the profession, giving special attention to furthering the interests of those engaged in general practice. Thanking you for your courtesy in permitting me to address your readers through your valuable columns,

I remain, Sir, yours truly,

GEORGE BROWN.

Mount Lodge, Callington, Cornwall,
October 6th, 1906.

MOTOR-CARS AND DUST.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I have read with considerable interest the correspondence on this subject; interest I mean of a personal kind, as early in the present year I contemplated joining the throng, by giving up my carriage and starting a motor-car. Your correspondent, Dr. Gilchrist, who strongly champions the modern method of locomotion, admits that the dust evil can scarcely be exaggerated, but he adduces as a strong point in favour of the motor-car, "its rapid adoption as a substitute for the omnibus drawn by horses in the streets of London will, it is hoped, discourage the development of the tramway." If your correspondent lived in London instead of at Nice, I fancy he would hold a very different view on this subject. We in London, and doubtless the same view is held in other large cities, consider the motor omnibus as one of the greatest curses of modern civilisation. Its stench, its deafening rattle, and its constant liability to a breakdown—apart from the terrible death-roll with which it has been ushered in—have rendered our main thoroughfares well-nigh intolerable. To quote from one of our highest-class newspapers of Wednesday last:—"It is no good beating about the bush—the motor-bus is a monstrous plague. Life is a torture on any of the main 'bus routes. The noise, the smell, the ugliness, the danger to life and limb—these are reducing many a noble thoroughfare to an Inferno."

Then to remedy the dust evil which motor-cars have created, Dr. Gilchrist suggests the making of special highways, or the widening of existing ones to accommodate followers of the new craze. Thus the already overburdened ratepayers are asked to pull down houses and make new thoroughfares for the few who have suddenly discovered that they cannot travel fast enough in horsed vehicles, regardless of the cost entailed thereby on the public and the ruin of property *en route*. I can only congratulate myself that I did not give way to my first impulse; my horse is still fast enough to take me to my patients' houses, and I have it not on my conscience that the public are being made to pay for my gratification.

I am, Sir, yours truly,

A LONDON PHYSICIAN.

OBITUARY.

THE RIGHT REV. MONSIGNOR MOLLOY, VICE-CHANCELLOR OF THE ROYAL UNIVERSITY OF IRELAND.

ALTHOUGH the late Rector of the Catholic University of Ireland was not a member of the medical profession, his connection with the knowledge of sciences closely allied to medicine were such that we feel we cannot allow his unexpected death to pass unnoticed. As our readers know, Monsignor Molloy passed away whilst staying at Aberdeen, on the occasion of the recent University celebrations. His life was a many-sided one, as, in addition to his theological work, he was deeply interested in science, and was well known to the Dublin public by virtue of the many and lucid lectures which he has delivered from time to time on scientific subjects Indeed, his grasp of the latter was such that he was able to make the most abstruse of them clear to a non-scientific audience. In 1874, Monsignor Molloy was appointed Professor of Natural Philosophy to the Catholic University, and this position he held until 1887. In 1882 he became Rector of the Catholic University. He was a member of the Council of the Royal Dublin Society, and in the lecture rooms of that famous body he delivered many of his lectures. In 1903 he was appointed Vice-Chancellor of the Royal University of Ireland, and at the time of his death he was representing that institution at the Aberdeen celebrations. Monsignor Molloy enjoyed a wide popularity both for his scientific attainments and also for his social gifts, not only amongst those who belonged to the same school and religion, but amongst those who differed widely from him. In the latter connection his loss will be deeply felt throughout the entire of Ireland, for he constituted a link between men of different views at a time when other men in similar positions are striving to create discord. Whether anyone can be found capable of taking his place time will show. Should he be found, there is a wide field for his labours, and never was he more urgently required.

WILLIAM CRAWFORD PALMER, L.R.C.P.&S.Ir., L.M.

WE regret to announce the death of Mr. W. C. Palmer, who died suddenly at Birkenhead on September 28th, where he was taking charge of the workhouse infirmary. According to evidence given by Nurse Amy Braithwaite, the deceased on Friday morning went to the surgery at the workhouse hospital. He appeared in good health, and it was while he was writing out a prescription that witness heard him exclaim, "Oh, sister!" He fell back in his chair and became unconscious. Dr. Stansfield arrived at the institution shortly afterwards, but found that Mr. Palmer was then dead. In his opinion the contributory cause was angina pectoris.

SPECIAL ARTICLE.

THE LONDON MEDICAL EXHIBITION.

The London Medical Exhibition, held last week at the Royal Horticultural Hall, Westminster, was a great triumph for our enterprising contemporary, the "British and Colonial Druggist." The exhibition was only the second that that journal has organised, but in variety and interest of exhibits, in excellence of organisation, and in amount of patronage secured it is difficult to conceive of anything more successful. Indeed, medical men generally—or, rather, those who paid a visit to the Exhibition—are under a debt of gratitude to the organisers for their care and foresight, and for giving them the opportunity of seeing many things which they had heard or read of, but never seen. We only hope that they suffered no financial loss, for their hospitality and courtesy deserved more than a mere *succès d'estime*. Every arrangement that could be made for the comfort and convenience of visitors had been carefully thought out and arranged, and we fancy that Mr. Norman Flach, the secretary, to whom "complaints" had to be made, must, whatever his other duties entailed, have had an easy time on that score. The spacious Horticultural Hall was got up in attractive style, and excellent orchestras played with scarcely an interval during the whole time—11 a.m. to 6 p.m.—the exhibition was open each day. There were cloak-rooms provided for both sexes, a reception-room where visitors were kindly entertained by the "British and Colonial Druggist" staff, and capital refreshment rooms. If there were a criticism to offer, it would be that six o'clock was rather early for the closing time, as many practitioners who were busy in the daytime would have been glad to go in the evening. At any rate, a large and satisfactory audience was secured, and no one who went, we are sure, considered the time ill-spent. As to the

exhibitors themselves, they equally must have been satisfied with the opportunity afforded them of introducing their goods to the notice of so large a number of practitioners.

To give a detailed account of the wealth of exhibits would carry us far beyond the limits of our space, and we can here but note some of the inventions and products that struck us particularly; but when we have said all we have to say, we shall be constrained to say with the Queen of Sheba, "the half hath not been told." A hundred and two firms had taken stands, to say nothing of those who sent photographs and plans of sanatoria, nursing-homes, and so on, so that to have got a complete knowledge of all that was on view would have entailed a visit every day for the seven hours the exhibition was open.

Opposite the main entrance was Armour's, a firm who have safely weathered the storm of abuse that swept over Chicago and all its packing firms. The Americans are nothing if not hysterical, and the British, thanks to the American methods of journalism that have established themselves over here, are apt to follow the Transatlantic lead. Now, however, that people are coming to their senses, they are beginning to find out slowly that the "Jungle" exposures were in a measure the result of a carefully laid campaign by a journalist in search of copy. That the Chicago packing-yards were above reproach cannot be maintained in these days, when people demand, and rightly demand, a high standard of hygienic excellence in the preparation of their foods; but at any rate, Armour's medical products are prepared in special workshops, under "laboratory" conditions, and no sort of reflected odium could attach to them. Their newest preparations, the "Elixir of Enzymes," a fluid containing the active principles of all the digestive ferments, and "Eucapron Solution," a preparation containing Beta-eucaine Lactal and Suprarenalin, are very attractive. The advantage possessed by the latter that it can be sterilised by boiling without damage renders it a useful addition to local anæsthetic solutions. Southall Bros. and Barclay, Ltd., had many improvements in sanitary towels to show, foremost amongst which must be mentioned their compressed towels. These are ordinary towels subjected to such pressure that they are reduced to the size of about a large pill-box, and this advantage in all probability will commend itself to all women. Their accouchement sets, infants' "Knapkinettes," and dressings of all kinds exhibit the elegance which have made them famous; and special mention must be made of an ideal india-rubber hot-water bottle, the "Celerio," which gives no trouble in filling, and cannot leak. One of the smartest things that Messrs. Southall had on show was "Lofatol," an aërated cod-liver oil in syphon. The oil being charged with carbonic acid has a consistence which ordinary cod-liver oil cannot attain, and the "sting" produced in the mouth by the bubbles of gas disguises to a great extent the ordinary objectionable taste of this valuable drug. The "Idris" Company were showing a number of their well-known waters, and we learned for the first time that they can supply an artificial Vichy water in syphons. Moreover, they can supply a new radio-active water, "Igmandi," which is likely to be much sought after. A particular feature of their syphon is the spout, which is cleverly designed so that by no possibility can the contents of the bottle come into contact with the metal. "Perrier" was on view and on draught, and medical men who have not tasted this water will be glad to find how pleasant and refreshing it is. Mr. Zeal had a stall for his thermometers, and his two chief varieties, the Aseptic Clinical and Repello, are as useful as they are ingenious. The former can be kept always aseptic, as the thermometer itself is carried in a glass tube, which can be filled with antiseptic fluid, and the Repello, which is set without shaking, is a thing of beauty.

The Aylesbury Dairy Company had on show an infant food, "Pollyta," which they have recently brought out, and for which they claim a specially high percentage of fat; and besides these were specimens of their Humanised Milk, Humanoid, Peptonised Milk, Sterilised Milk and Cream, and Whey, all obtainable in bottles. Everybody knows, or should know, Messrs. Zimmerman's products—Chotropine, Chloralamide, and Piperazine are household words. Sublamin is newer, and was on view. It is a non-toxic, non-corrosive sulphate of mercury, and, if it acts as powerfully as is claimed, should seriously challenge the supremacy of perchcloride of that metal as a routine antiseptic. Many new organic products also were shown, and their stand alone was a lesson in materia medica and pharmacy. The same may be said of Mr. W. Martindale's. First, there was the new 12th Edition of the Extra-Pharmacopœia, the breviary of the progressive practitioner, and side by side with it the elegant preparations which it explains. "Sterules" are highly convenient glass capsules containing just enough of a preparation for one dose, and glass and gelatine capsules of various kinds make drug-taking and drug-giving a luxury. "Rodagen" is an interesting preparation, being the dried milk of thyroidectomised goats, which may have a field of usefulness in hypertrophic conditions of the thyroid; whilst the Oleogen series promise to be of great value in prescribing inunctions. The Jeyes' Sanitary Compounds Co., Ltd., had their Cyllin products on view. It is almost superfluous to say anything about these, so much are they appreciated for their high bactericidal properties; but it may not be generally known that the company now make surgical dressings impregated with Cyllin, and put up a dusting-powder, an inhalant, and a syrup—the latter for internal use.

(*To be concluded.*)

REVIEWS OF BOOKS.

LUNACY REPORT FOR IRELAND. (*a*)

THE Inspectors begin this report by reference to a former document of the same nature. In 1894, the conclusions arrived at were that the apparent increase in the number of the insane was "mainly due to accumulation," and was partly owing to a mere transfer from the unregistered to the registered "as shown in the reduction in the number of lunatics and idiots at large," but that yet "the annual increase, in face of a shrinking population, of the number of First Admissions, including such a large proportion of First Attacks of insanity, almost irresistibly pointed to some increase of occurring insanity in particular districts."

We do not know that the conclusions of the present report, to be presently referred to, are much more definite, but we learn enough from them to be pretty confident that the sensational statements so often made are exaggerated and that there is really no great cause for alarm.

There is, of course, no question that the number of registered insane has increased greatly of late years—from 9,980 in 1851 to 25,050 in 1901.

With regard to the special proportionate increase which is supposed to have occurred in Ireland in comparison with other countries, the Inspectors point out that this is, at least in part, a necessary consequence of emigration, "as it is clear that, although emigration reduces the general population, it does not reduce the number of the insane, as the number of those who leave the country when actually insane may be regarded as negligible."

That mere redistribution of the population may have much to do with the apparent increase is shown by a fact stated early and prominently in the report before us: "The return of the insane in Ireland, according to the last census, shows a diminution under all heads except in the numbers located in asylums." That the transfer of patients from one class to another does not indicate a change in the incidence of insanity is true, but persons sent to asylums are carefully registered and live longer than when wandering with-

(*a*) "Supplement to the fifty-fourth Report of the Inspectors of Lunatics in Ireland, being a Special Report on the Alleged Increase of Insanity."

out care or subject to the organised neglect of a workhouse. Besides, an increased number of admissions to asylum probably connotes not merely a transfer from one class to another of the registered insane, but the introduction into the register of a great number of persons whose insanity was previously altogether unregistered.

A very remarkable fact is pointed out by the Inspectors with reference to the age classification of the total insane: "The population under twenty years of age has very largely decreased during the thirty years from 1871 to 1901," while "the insane under that age have decreased at almost as great a rate." "The population between the ages of 20 and 55 showed decrease, while the insane of a similar age period increased by 64 per cent.; and the population over 55 also decreased, while the insane of that period showed an increase amounting to 185 per cent." These deductions are made from returns obtained from the Registrar-General, and it is very curious that they are supported by certain figures arrived at in quite a different way by one of the asylum physicians, whose reports are appended to that of the Inspector's. That gentleman has pointed out that in his district the proportion of persons admitted to the district asylum between the ages of 15 and 30 has not increased, but rather diminished (from 32.6 per cent. of the total admissions in 1886 to 28.1 per cent. in 1902). In a similar period the proportion of admissions over 50 years had risen from 15.2 to 23.6 per cent. The observations, of course, are not of identical value, but they tend to corroborate each other. We may gather that the "hereditary insanity of adolescence" (Clouston), the solid nucleus of that wonderful nebula "dementia præcox" (Kräpelin), which most modern authorities regard as the most hereditary and the most constitutional form of insanity, is not that which is increasing in Ireland. If the generally accepted views are correct there is hope in this fact, as it seems to show that the question is not one of race degeneration.

It is pointed out that, imperfect as asylum statistics must necessarily be, the best attainable criterion as to increase of insanity is the number of freshly occurring cases, and that this is best ascertained from the first admissions to asylums that have been not more than twelve months ill, when admitted. The proportion of cases of first attack not existing more than a year on admission to the total of admissions has not varied much in the decade which the Inspectors specially review, but their proportion to the population shows an increase from 3.94 per 10,000 of the population in 1894 to 5.07 per 10,000 in 1903. "It must be borne in mind, however, that there is nothing to show that the cases of first attack were taken from the young and vigorous members of the community. As we have shown elsewhere, a large proportion of them were cases of dotage or senile decay, who had never previously been insane." We venture to think indeed, that there is much to indicate that this is the principal explanation of the apparent increase in this instance. Everywhere, and notably in London County, there is the same complaint, that of late years a great proportion of the cases admitted are senile dements—of course, incurable, but often enough intractable, and almost always requiring a great deal of care. The cause for the increased admission of this class of late years is obscure. The greater longevity of the population contributes, and probably also changes in the habits of the people, who find it harder to manage a doting relative in their homes. Decreasing toleration of the insane and feeble, diminishing sense of responsibility for those whom the State is supposed to care for, together, perhaps, with greater confidence in asylums, may be further contributory agencies.

The increased longevity of asylum patients accounts for a considerable accumulation in those institutions. The death-rate in the Irish asylums has been steadily falling for many years. In 1883, it was 9.4 per cent. on the daily average number resident, while in 1903 it had fallen to 7.8 per cent. It is noted that in one of the largest asylums the death-rate has fallen by one-half within the last twenty years. The Irish death-rate is considerably lower than the English (10.4 per cent. for the whole of the County and Borough Asylums in the year 1903). This is no doubt chiefly due, as the Inspectors pointed out, to the greater mortality in the latter country from general paralysis (some five or six times greater than in Ireland).

Contrary to what the *a priori* reasoner would expect, the Irish Inspectors find, like their Scotch colleagues, that the proportion of the insane to the population is greatest in the most remote rural districts and least in the large centres of population.

On the causation of insanity the Inspectors wisely abstain from dogmatising. We have not noticed anything about the marriage of near kin (probably less prevalent in Ireland than anywhere else in the world) which we used to hear about, and we are glad to find that what we have always supposed to be a private "fad" of Mr. John Morley's, namely, that the curative operation of asylums increases the hereditary predisposition to insanity of the general population, has been given the go-by. There never seems to have been a shred of evidence to support this purely doctrinaire notion.

The influence of emigration has received much attention. The sane go; the insane remain. Emigration is to England or America; the homing instinct of the Irish often brings the yearning invalid back to his native land, where the process of decay, perhaps started abroad, develops into complete ruin.

The Inspectors draw attention to the number of the Irish who become insane in America, as shown by the statistics of American asylums. It is out of fashion to assign "moral" causes for mental disease. We venture to think, nevertheless, that such conditions as nostalgia are very genuine and are probably not of bacterial origin. We are of opinion that the simple peasant from a hillside in Mayo or Galway, a man with the narrowest outlook of any man in Europe, perhaps, is apt to lose his moral bearings when thrown into the whirl of life in an English or American manufacturing town, and that this happens far less from racial peculiarities than from educational and environmental surroundings.

In summing up, the Inspectors tell us virtually that it is impossible to state positively whether an increase of occurring insanity has taken place; that a numerical increase among the registered insane which has undoubtedly taken place is mainly among the rate-supported insane; that the increase of asylum patients is due to accumulation; to absorption of the unregistered insane; to a widening in the application of the term insane; to greater public confidence in asylums; to an increase and greater accessibility of asylums; to greater longevity both of the general population and also of the asylum population; to the return of broken-down emigrants; and, finally, "to the fact that the Celtic race, notwithstanding their undoubted intellectual gifts, are peculiarly prone to mental disease." This last conclusion the Inspectors offer with some suggestion of doubt. We are inclined to think it is very far from definitely proven.

A New Journal.

"L. G. O." is the name of a new journal, if one may apply that description to the incorporated descendant of two previously existing publications. The two parties to this coalition were the "Local Government Officer" and our old and valued friend the "Public Health Engineer." "L. G. O." appears with the announcement that it is the official organ of the local government officers. We wish it a long lease of life, and feel that we may do so with entire confidence, knowing the past traditions of thoroughness and business-like enterprise that governed the "Public Health Engineer." With the other party to the embodiment we are not so well acquainted, but its reputation is excellent. The copies of the new journal with which we have been favoured are excellent in form and substance.

MEDICAL NEWS IN BRIEF.

Bath's Prosperity.

While in so many cities and towns throughout the country to-day residents are lamenting the increase of local rates, it is a remarkable fact that in a city possessing the residential advantages of Bath, the Municipality have been able to make a reduction in the rates of the city to the extent of 6d. in the £. Thus for the current year the demand will only be 5s. 10d. in the £ as compared with 6s. 4d. for the year ended March, 1906. This gratifying intelligence for the residents of Bath was announced at a meeting of the Town Council held on Tuesday, and will no doubt cause envious eyes to be turned in the direction of Bath as a place of residence. Important factors in this large decrease of local taxation have been the increasing value of Corporate property in recent years (an increase which will naturally continue as old leases fall in), and the prosperity of the famous bathing establishments, which are attracting visitors in increasing numbers annually. One great advantage which Bath possesses over the other principal resorts for the water "cure" is that its mild and equable winter climate has made it an all-the-year-round resort, and it may, therefore, be visited when many of the continental resorts are closed. Those of the travelled community who have visited the stately city of Bath will know that there are few more charming spots in Europe, and the knowledge that its civic finance shows so healthy a state should do much to further increase its popularity as a residential centre.

Research at Khartum.—The Wellcome Laboratories.

THE second report of the Wellcome Research Laboratories at Khartum has just been issued in a handsome quarto volume of 255 pages, enriched by several excellent plates, coloured and uncoloured, in addition to numerous photographs and maps. These laboratories were established three years ago at the Gordon Memorial College, Khartum, by Mr. Henry S. Wellcome, as a free gift to the Sudan Government, and are intended, among other objects, to promote the study of tropical disorders, especially the infective diseases of both man and beast; to study the toxic agents employed by the natives; to carry out such chemical and bacteriological tests in connection with water, food stuffs, health, and sanitary matters as may be found desirable, and to undertake the testing and assaying of agricultural, mineral, and other substances of practical interest in the industrial development of the Sudan. The director, Dr. Andrew Balfour, has been so successful in his pioneer work that his staff has been strengthened by the addition of a chemist (Dr. William Beam) and a travelling pathologist and naturalist (Dr. Sheffield Neave). A valuable adjunct in the shape of a floating laboratory will likewise be placed at his disposal before long. He has enlisted, moreover, the sympathies of several officers, both medical and veterinary, employed by the Sudan Government, and is getting much assistance from them as collectors and inquirers. The "mosquito brigade" has been doing good work, not only in Khartum, but in the Anglo-Egyptian Sudan generally, and the report gives statistics on the subject. There are valuable papers on other biting insects besides the mosquito, including the deadly tsetse fly. There is one on vegetal pests by Mr. F. V. Theobald, and one by Dr. Balfour on trypanosomiasis in cattle and mules. An institution of this comprehensive character must needs prove of incalculable benefit to the country with which it is more immediately concerned, while it cannot fail to act as a useful auxiliary to home schools of tropical medicine.

Death Under Chloroform at North Shields.

MR. RUTHERFORD, deputy-coroner, last week held an inquest in the Town Hall Buildings, North Shields, concerning the death of Harris Hamilton, 42, donkeyman, in the Tynemouth Victoria Jubilee Infirmary. Harriet Hamilton, widow of the deceased, said that, on the 18th ult., her husband returned from South America. During the voyage he and several members of the crew were attacked with yellow fever, and he was still suffering from the effects when he came home. He was also bitten on the left hand by an insect while in the engine-room of his vessel, and after he returned home the wound became inflamed. He consulted Dr. Baker on Wednesday, and on the following day went to the Infirmary, where he died.—Dr. Baker stated that the deceased consulted him on Wednesday about a growth on the back of his left hand. It was a "warty" growth, the size of a florin, and might have been caused by the bite of an insect. The deceased and his wife were both anxious that something should be done, and witness told him to go to the Infirmary next morning to undergo an operation. Witness went to the Infirmary at 10.50 a.m. on Thursday, and administered chloroform to the deceased in the presence of a nurse. After he had done so, witness was joined by the house surgeon, who performed the operation of cutting away the growth. This lasted only a few moments, and it was practically finished when witness noticed that the man was breathing badly. The deceased was a strong, healthy-looking man. Before administering the anæsthetic witness took all the necessary precautions. After the patient's collapse artificial respiration was kept up for over two hours, and several other means of restoration were tried without avail. It was likely that the attack of yellow fever, of which witness had not been told previously, had weakened the man's system.—The jury found that the deceased met his death while undergoing an operation under chloroform, which was properly administered.

Medical Sickness and Accident Society.

THE usual monthly meeting of the executive committee of the Medical Sickness, Annuity, and Life Assurance Society was held on the 28th ult. There were present Dr. de Havilland-Hall, in the chair; Dr. J. Prickett, Mr. William Morris (Birmingham), Dr. St. Clair B. Shadwell, Dr. M. G. Biggs, Mr. H. P. Symonds (Oxford), Dr. F. S. Palmer, Dr. J. Brindley James, Dr. J. W. Hunt, Mr. Edward Bartlett, Dr. W. Knowsley Sibley, and Dr. J. B. Ball. The records of the Society for the summer months is exceptionally good, and has already balanced the heavy disbursement for sick claims which, as usual, was experienced in the early spring. The number of new entrants is above the average, but less than in last year, when the record number of new members was obtained. The committee are pleased to find an increased proportion of dental surgeons among the new entrants. All the benefits of the business can be obtained by members of this branch of the profession, and it is hoped that their numbers in the Society will rapidly grow. Prospectuses and all further particulars on application to Mr. F. Addiscott, secretary, Medical Sickness and Accident Society, 33, Chancery Lane, London, W.C

Girl's Death under Chloroform.

At the Keighley Victoria Hospital, Leeds, last week, when a girl of 14 was about to be operated upon by Dr. Moffat for deformity of the legs, Mr. J. N. Dobie administered chloroform after finding that the patient's heart appeared to be sound. Twenty minutes later she suddenly expired. The case has been reported to the district coroner.

A Novel Inkstand.

We have an inkstand before us of which the director of the "Association for the Supply of Pure Vaccine Lymph" is the inventor. Let it be remarked that this gentleman assumes no connection between ink and vaccine, but as a practical man of business he has put on the market this "Sapphire" inkstand, which strikes us as an ingenious attempt to supply an inkpot in which the level of the ink never falls. This is attained by providing an acid-proof india-rubber reservoir of the very best quality which is sufficiently compressed as required by turning round the top of the inkstand. A little glass cup like a minim measure passes into the reservoir, and into this cup the pen is dipped. The Sapphire will help to ease the minds of writers with bad memories or forgetful servants.

North-East London Clinical Society.

The opening address of the Session will be delivered at the Tottenham Hospital to-morrow (Thursday), October 11th, at 4.30 p.m., by Sir John Halliday Croom, who will take as his subject "Exophthalmic Goitre in its Obstetrical and Gynæcological Aspects." All medical practitioners are cordially invited.

The Annual Dinner of the Society will be held on the same evening at 7 for 7.30, at the Great Eastern Hotel, Liverpool Street, when the President, Dr. Arthur Giles, will occupy the chair. Members of the Society are reminded that ladies are invited to the dinner, and that tickets, price 7s. 6d., exclusive of wine, can be obtained from the honorary secretaries, Dr. G. P. Chappel, Lansdowne House, Tottenham, and Mr. C. E. Hutt, 626, High Road, Tottenham, N.

Hop-Pickers and Small-pox.

At a meeting of the Alton Rural District Council last week, the medical officer reported that a hop-picker who had been living in the hoppers' barracks at Froyle had developed small-pox at Andover the day after he left Alton. The premises used by the pickers have been thoroughly disinfected, and the utmost precautions have been taken to prevent the spread. No further cases are suspected.

PASS LIST.

Royal College of Physicians and Royal College of Surgeons in Ireland.

Preliminary Examination.—Candidates have passed this Examination as undernoted.—U. L. Bourke, J. J. B. Breakey, D. Burns, C. H. Christal, H. Cochrane (with Honours), A. N. Cole, A. H. Crely, T. Dowser (with Honours), R. M. Erskine, F. C. Fisher, J. Fitzgerald, M. Golding, A. F. C. Hogg, C. W. Joynt, H. R. L'Estrange, F. J. Meenan, S. H. Moss, C. E. Murch, R. J. McArdle, P. H. McDough, A. J. Neilan, J. L. Nunn, H. V. Odlum, L. O'Donovan, R. H. Orr, K. L. O'Sullivan, J. C. Sproule, V. J. White, and W. Williams.

First Professional Examination.—H. E. Clarke, H. D. Gasteen, J. Germley, J. J. Glynn, J. D. Hamilton, E. E. Holden, R. H. Hodges, W. V. Johnston, A. P. Kennedy, A. M. A. Lanphier, L. A. Moran, W. H. Murray, H. McAdee, J. McMullen, T. B. Newman, M. A. O'Callaghan, B. O'Donnell, J. H. O'Neill, J. Purcell, A. Wiley.

The Royal University of Ireland.

The following candidates have passed the Third Examination in Medicine, Autumn, 1906:—

Upper Pass.—*David S. Clarke, B.A., *William Faith, James Ferguson, B.A., *Michael P. Fitzgerald. William P. MacArthur, John J. McGrath, Kenneth F. Mulligan, *John A. Sinton, Verner Wiley. Candidates whose names are marked thus (*) may present themselves for the further examination for Honours.

Pass.—Robert J. Clarke, Alexander W. Connolly, Hugh J. Grant, Patrick Keelan, Peter J. Keogh, Alan Kidd, John C. Macaulay, Samuel W. McComb, William C. McCullough, Robert A. McLaverty, Hamilton Mathewson, Ulick J. G. Mulligan, Patrick J. O'Brien, B.A., Michael O'Connell, David O'Sullivan, Michael Shipsey, Bruce A. West, John N. Williams.

University of Durham—Faculty of Medicine.

The following candidates have passed the first examination for the degree of Bachelor in Medicine:—

1.—*Elementary, Anatomy and Biology, Chemistry and Physics.*—Eva Lumb.

2. *Chemistry and Physics.*—Isaac Bainbridge, John Akilade Caulcrick, Helen Grace Clark, Robert Vickers Clayton, John Hare, John Parkinson Higham, Howard Tomlin Hunter, George Eric Warner Lacey, Samuel Littlewood, Eric Hemingway Shaw, Stanley Worthington, James Carruthers Young.

3. *Elementary Anatomy and Biology.*—Eliot Watson Balke, Elliot Jessie Ramsbotham, Madeline Rosa Shearburn, Olivia Nyna Walker.

The following candidates have passed the Third Examination for the Degree of Bachelor in Medicine:—*Pathology, Medical Jurisprudence, Public Health, and Elementary Bacteriology.*—Honours—Second Class.—Charles F. M. Saint, Elizabeth Patteson, David Ranken. *Pass List.*—Kenneth Bruce Allan, Herbert Ridley Crisp, Henry Glendinning Davison, Harold Ferens, Charles Westland Greene, Isaiah Hodgkinson, Frank Widowfield Melvin, Charlotte Purnell, Francis AidanRobinson, Edward Davison Smith, Basil Taylor, John Henry Tripe, M.R.C.S., L.R.C.P., Lionel Langford Westrope, Frank Whitby.

St. Mary's Hospital Medical School, Paddington.

The following awards have been made as the result of the Entrance Scholarship Examinations held on September 24th, 25th, and 26th:—

Open Scholarships in Natural Science.—£145 and £78 15s. G. Roche Lynch, St. Paul's School, and R. G. Sparkes, Felsted School, equal. The sum of the two scholarships equally divided. £52 10s., A. Murray Stuart, Cheltenham College; £52 10s., P. Withers Green, Epsom College.

University Scholarships.—60 guineas, W. D. Hopkins, B.A., Trinity Hall, Cambridge; 60 guineas, F. G. Caley, B.A., Pembroke College, Cambridge, G. H. Drew, B.A., Christ's College, Cambridge, equal.

The *Epsom College Scholarship* (value £145) has been awarded to T. W. W. Powell, a student of the College, on the nomination of the Headmaster.

Charing Cross Hospital Medical School.

The following Entrance Scholarships have been awarded:—The Epsom Scholarship (115 guineas), to Mr. B. F. Eminson. The Livingstone Scholarship (100 guineas) to Mr. N. C. Lake. The Huxley Scholarship (55 guineas) to Mr. H. Smith. Entrance Scholarships have also been awarded to Mr. R. F. Eminson (60 guineas) to Mr. A. E. Huxtable (40 guineas), to Mr. M. Barker (30 guineas). Universities Exhibitions of 36 guineas each have been awarded to Mr. F. C. Davies, Cambridge University, and Mr. E. A. Ramsden, Oxford University.

Guy's Hospital Medical School.

The following Entrance Scholarships and Certificates have been awarded:—

Senior Science Scholarship for University Students.—£50, A. H. Crook, B.A., Christ's College, Cambridge. Certificate, C. C. Holman, B.A., Caius College, Cambridge.

Junior Science Scholarships.—£150, F. Cook, Preliminary Scientific (M.B.) Class, Guy's Hospital. £60, E. G. Schlesinger, Scientific (M.B.) Class, Guy's Hospital. Certificate, G. T. Smith, Alleyn's School, Dulwich.

Entrance Scholarships in Arts.—£100, W. A. Young, Colfe Grammar School, Lewisham. £50, H. Webb Rossall School. Certificate, N. E. Farr, St. Paul's School.

Entrance Scholarship in Dental Mechanics.—Mr E. A. Tomes.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS. ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT MEDICAL LITERATURE.

Post-Typhoid Periostitis and the Typhoid Spine.—Wilson (*The Med. Chronicle*, August, 1906) discusses these two conditions and the relations between them. Post-typhoid periostitis occurs in about 1 per cent. of typhoid cases, but in comparison with the other acute specific fevers the complication is common. The typhoid spine is much less common, and only some forty cases have yet been described. The condition appears to be more common in men than in women. The onset is usually gradual, the patient complaining of weakness and pain in the back when first allowed to sit up after his fever. In some cases the pain does not set in till several weeks or months after the fever. In nearly all the cases the preliminary aching has been followed by very severe pain, which may continue for as long as four months. Remissions and exacerbations are common, and the recovery is slow and gradual, some pain and weakness persisting for a year or more. In about half the recorded cases there was an irregular pyrexia, the temperature ranging between 100° and 103° F. All the recorded cases with one possible exception recovered. Some spinal deformity resulted in eleven of the cases. Gibney, who first described the condition, considers that it was the result of an inflammation of the periosteum and of the fibrous structures binding the spinal segments together. This explanation has been generally adopted by other writers, but some, including Osler, describe the condition as a neurosis similar to that known as "irritable spine." The great difficulty in the way of accepting a periostitis as the explanation is that in no case has there been any sign of suppuration, though suppuration is the usual result of post-typhoid periostitis in other parts of the body. Those who would explain the condition as a neurosis attribute the spinal deformity that sometimes occurs as due to an associated tuberculous lesion. The presence of a very pronounced Widal's reaction with the blood during the attack suggests strongly that the organism was the typhoid and not the tubercle bacillus. K.

Massive Doses of the Salicylates in Rheumatic Fever—Clarke (*American Journ. Med. Scien.*, September, 1906) deals with the value of large doses of salicylate of sodium in the diagnosis and treatment of acute rheumatic fever. The tendency of late years at the Lakeside Hospital has been to increase the dose, and the seventy-four cases treated during the last six years are analysed with a view of estimating the value of this treatment. An administration of 240 grains or more in the 24 hours is considered a large dose. The routine treatment is to give the drug in doses of from 15 to 20 grains every hour while the patient is awake until toxic symptoms are evident. When the first sign of toxic symptoms is evident the administration is stopped; when these symptoms have disappeared the drug is given every two hours. The effect on the fever is very marked, and a composite chart of the seventy-four cases shows that in 36 hours the temperature became normal, and did not afterwards rise above 99° F. As a rule, the pain and swelling are completely gone by the fourth day, and in only four patients did any joint become involved after the treatment was begun. In only 13 per cent. of the cases was there any endocardial complication, and in one case pericarditis. There was one fatal case, a patient who took 580 grains at the rate of 20 grains an hour before any toxic symptoms developed; for two days he did well, then suddenly became wildly delirious, and died on the tenth day. The *post-mortem* examination showed œdema of the brain, and vegetative endocarditis. It is doubtful whether death was due to salicylic poisoning or to rheumatic meningitis. It was found that on an average the true rheumatic patient could tolerate from 150 to 300 grains of the drug before showing any toxic symptoms, while persons suffering from other forms of arthritis became toxic on much smaller doses, the gonococcic cases, for instance, averaging 131 grains. Further, any patient having fever and pain after 48 hours' treatment is looked on as a doubtful rheumatic, and careful search instituted for the underlying cause of the arthritis. K.

Digestion in Pancreatic and Gall-Bladder Disease—Buysch has investigated (*Zeitschr. für Klin. Med.*, Bd. 58, S. 518) the digestive and absorptive processes in a series of patients who were suffering from pancreatic diseases. He finds that, when the outflow of pancreatic juice is more or less diminished, the fat absorption is most interfered with, and that from 50 to 60 per cent. of the ingested fat apears in the fæces. On the other hand, the splitting of the fat molecule into free fatty acid and glycerine is not inhibited, and considerable quantities of soap are found in the bowel. The loss of proteid in the fæces averages 20 per cent. When, in addition to the absence of pancreatic juice, the bile is also cut off from the intestine, from 80 to 90 per cent. of the fat is lost, and about 33 per cent. of the proteid. The carbo-hydrate is under both circumstances well absorbed. Intestinal catarrh and increased peristalsis have the same effect as pancreatic disease in increasing the amount of material lost in the excreta. While in icterus alone the dried fæces can contain up to 80 per cent. of fat, in pancreatic disease not more than 60 per cent. is present. This is explained by the fact that in the latter case proteids also figure largely in the fæces, and shows that one can draw no definite conclusions concerning fat absorption from mere percentage analyses. In all cases, in fact, the total quantities excreted, as compared with the total quantities ingested, must be determined. Buysch has also shown that emulsified fat is no better absorbed than ordinary fat in pancreatic disease, and he has proved that in cases of diabetic acidosis the diminished alkalinity of the intestinal secretions may lead to a diminution in the digestion and absorption of fat. In such cases as these last mentioned one cannot, therefore, from the presence of much fat in the fæces diagnose the existence of pancreatic trouble. M.

Cardiac Massage.—Investigations carried out on the hearts of men who had just died has shown (*Wiener Klin. Rundschau*, 1905, No. 50-52) that that organ retains its power of contraction under the influence of certain stimuli for about an hour after somatic death. Among the stimuli employed is the procedure advocated by v. Prus—*i.e.*, resection of a couple of ribs, opening the pericardium, and rhythmical compression of the heart by the hand. Whilst in men, in whom this procedure had been carried out for the relief of chloroform syncope, no revival took place, the contrary was found in animals, which could be easily revived after deep choloroform narcosis. The difference, according to Müller, the author of the paper, lies in the fact that in the animals the heart is sound, while in men who die under chloroform the heart is always diseased. Along with massage, one may endeavour to bring about a direct flow through the heart. This is done by introducing a canula into a large vein in the arm, and transfusing under high pressure warm saline solution. Along with this the direct manual compression should be practised, but it is enough to introduce two figures into the pericardial sac for that purpose. The author thinks that the procedure is worth trying, not only in chloroform narcosis, but also in death from coal-gas and the like, provided that

no post-mortem rigidity has made its appearance. The injections especially act as powerful cardiac stimulants, and should be repeated if necessary. The paper is based on experiments on five animals, four of which were revived by the method described. M.

Typhoid Nodular Colitis.—Whipple gives a detailed account (*Johns Hopkins Hosp. Bulletin*, August, 1906) of the pathological findings in the colon of a case of colo-typhoid. The patient was a man aged 37, who was admitted to hospital for cardiac failure, and who died there without presenting any signs pointing to abdominal trouble. At the post-mortem, mitral stenosis and associated passive congestion of the liver and other organs were found, but, in addition, typhoid lesions were found in the large intestine. The stomach and small intestine were normal, and there was not the slightest swelling of the agminated or solitary follicles. The mucous surface of the cæcum and colon was thickly covered over with small sessile nodules from 2-10 m.m. in diameter, and which projected about 4 m.m. from the surface. The larger nodules were ulcerated on the surface, the ulcers being clean-cut and in places extending down as far as the muscularis mucosæ. The rectum showed intense congestion, but no nodules. Microscopically it was found that the solitary follicles of both large and small intestine were perfectly normal, and even those that were within or in the neighbourhood of the nodules were hardly altered. The nodules themselves were made up of an œdematous stroma, the predominating cells being large, oval, epithelioid cells with eccentric nuclei and few granules. Some lymphoid and neutrophile cells were also present, and there were small scattered areas of necrosis. The writer lays great stress on the distinction between these structures and hyperplastic lymphoid follicles, and maintains that the term nodular enteritis should be limited to the former condition. Actual lymphatic hyperplasia is chiefly found in children dying from acute infections, and the nodules found in such cases are much more evenly distributed over the colon. It is also pointed out that typhoid intestinal lesions limited to the colon are very rare, this being the first case encountered out of 217 autopsies in typhoid patients. Very few cases also are reported in the literature, and only three undoubted examples could be discovered. On the other hand, some involvement of the colon, along with the iliac lesions is usually met with. M.

Auto-Prognosis.—Landolfi (*Gaset. d'Ospedali*, Milan, 1906) is convinced of the great value of Gilbert's method of auto-sero-diagnosis, which consists in reinjecting, subcutaneously, serum or effusion taken from the patient's own pleura or peritoneum. A febrile reaction follows when there is tuberculous infection, but not if no tuberculosis is present. Landolfi has been studying the reaction obtained, and he states that it is able to afford important information, not only as to the tuberculous nature of the lesion, but also as to its seriousness and the ultimate outcome. For these points the particulars of the reaction must be recorded for several days after the injection, the curve then showing details which differentiate the affection and announce the outlook. The prognosis is graver the less the amount of effusion required to obtain the febrile reaction. The less the reaction and the tardier its appearance the milder the affection. In the days following the primary febrile reaction the temperature may surpass that first obtained, or it may equal or not approach it, the severity of the affection being announced by the prolonged reaction. In case of a negative response, the amount to be reinjected can be increased from 1 to 2, 3, or 10 c.c. If there is no response after this large amount has been injected, and if the temperature remains unchanged or varies very slightly during the days following the injections, the prognosis may be regarded as extremely favourable. D.

Treatment of Diabetes Insipidus with Strychnine.—Ketby (*Ther. d. Gegenwart*, Berlin, August, 1906) found injections of strychnine nitrate extremely useful in three cases of idiopathic diabetes insipidus. He commenced with .5 mg., increasing every second day by .1 mg. to a maximum of .01 gm. The patients were three men from 31 to 36 years old. The subcutaneous injections were given daily for about a month in one case, and then the strychnine was given by the mouth for three days. The amount of urine dropped from 8,000 to 1,500 c.c., and all the symptoms permanently disappeared. In another case the diabetes persisted after the cure of a syphilitic brain trouble under mercurial treatment. Under the strychnine injection the amount of urine declined from 11,500 to 3,000 c.c. in 13 days, and the polydipsia vanished with the polyuria. This improvement was only temporary, however, as the symptoms recurred in two or three months. They subsided again under strychnine by the mouth. One female patient did not show any improvement under the strychnine. D.

Resume of World's Cancer Research.—Bainbridge (*Med. Record*, New York, Sept. 1, 1906) states that cancer occurs with the same essential characteristics throughout the vertebrate creation. There is a variety of conflicting evidence in reference to the influence of diet on the development of cancer. Cancer is comparatively rare in hot countries, especially in those whose inhabitants subsist largely on vegetable diet. With certain exceptions it seems to be prevalent where animal diet is mostly consumed. Black races are remarkably immune from cancer; yellow races are more prone to it; while the white races are the most susceptible. It occurs when the tissues are undergoing retrograde metamorphosis. Cancer is undoubtedly on the increase. The principal increase involves the alimentary tract. There are certain districts called "cancer belts." Such areas are usually low-lying and damp. Women are attacked by cancer far earlier and more often than men. More recent experimental work points to the cell as the essential element in the development of cancer. The parasitic theory is discredited by the Harvard Commission. The report of the Imperial Cancer Research Fund destroys all known theories of the origin of cancer, but proposes no new theory. Surgical treatment has been established on a firmer basis than ever before. D.

Family variety of Enuresis Nocturna.—This condition is most unusual, and Stern (*Weiner Klin. Randschau*, 1905, No. 22) has only been able to find one record in the literature at all similar to the group that is now reported by himself. All the children born in a first marriage were healthy, but all those born after a second marriage to a neurasthenic father suffered after their sixth year more or less from incontinence. The eldest daughter, now 16 years old, first became affected between her 8th and 10th year, but was ultimately cured by electrical treatment. In three sons, aged 14, 10, and 6 years respectively, the enuresis had persisted since birth. The oldest of these was the most troubled, and suffered also during the day from polyuria and from weakness of the visual sphincter. The fifth child, a 13-year-old girl, was healthy up to her tenth year, but from that time began to suffer at intervals. The mother had died of acute nephritis after her last confinement. The writer regards the above-described condition as a definite inherited neurosis. M.

The use of Cyllin in the treatment of Mediterranean Fever.—McNabb (Navy Blue Book) gives an interesting account of the treatment of 42 cases of Mediterranean fever which occurred on H.M.S. "Implacable." Numerous drugs were tried, but the only one which appeared to be of avail was cyllin, a derivative of creasote. It was administered in the form of tablets, each of which contained 3 minims. Of the 42 cases dealt with, 10 had neither pyrexia nor symptoms, and so were dismissed from the list. The remaining 32 McNabb divides into two groups: 24 cases which were not treated with cyllin, and 8 which were so treated. The average duration of illness in the former class was 70.6 days, in the latter 38.5 days. Twenty-one cases suffered from painful local affections, which occurred in the region of the sacro-sciatic joint in seven cases, in three in the sciatic nerve, and in the remaining 11 in various nerves, muscles, and joints. J.

NOTICES TO CORRESPONDENTS, &c.

CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to 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 proofs.

CONTRIBUTORS are kindly requested to send their communications if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

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.

HERNIOTOMY.—Left duodenal hernia is rare of course, but quite a number of cases have been recorded—about 100 have been noted from time to time. For the points mentioned see "Ueber Intra-abdominelle Hernien und Bauchfelltaschen," by Brösike. Berlin, 1891.

R. WILSON.—Hypertrophic conditions of Luschka's tonsil may be regarded as a synonym, though perhaps not a happy one.

TRIPSIN.—Glycogen is present in many fungi, but in the large varieties it is consumed during growth.

DENS.—A good example of toothache "cure" has recently been patented and illustrates the point. It is a mixture of myrrh, alcohol, and chillies, capsicum, or other "pepper-like substance."

CANTABRIGIENSIS.—Your letter is under consideration.

THE TREATMENT OF RHEUMATISM, GOUT, &c., BY FANGO DI BATTAGLIA.

DR. HARRINSON, Physician to Smedley's Hydro, Matlock, writes us in reference to a letter which recently appeared in our columns on this subject, signed C. Vetter. He says, "My former statement that Fango di Battaglia is used at Smedley's Hydro, Matlock, as well as at the Royal Hotel Baths, Matlock Bath, I am prepared to stand by, and I can guarantee that the treatment has been given as well at Smedley's as at any other institution."

DISPENSER.—There is an Association of Women Pharmacists for supplying qualified dispensers. Address, the Secretary, Association of Women Pharmacists, Gordon Hall, Gordon Square, W.C.

L.R.C.P.—The circumstances make correct action very difficult. Without committing ourselves to a definite view in the matter, in the absence of fuller information, we should say it was highly indiscreet.

F.R.C.S. (Edin.).—The "Hammond" typewriter is a good machine, especially with the universal keyboard. Yes, you might do worse.

VAC.—An official illustrated guide and list of streets, boarding houses, and seaside and farmhouse apartments may be obtained from the Manager of the London and South-Western Railway. It is well got up and very useful.

R. A. G.—The word is seldom used, and is, as you remark, a mouthful for pronunciation. It is derived from the Greek, and is intended to describe a defect of vision, in consequence of which blue colour cannot be distinguished.

FOURTH YEAR.—The "Manual of Surgery" referred to is as popular as ever, and is not likely to be displaced, so long as the authors continue as in the past to keep it up to date.

MR. M. E. B. is thanked, but the contribution is scarcely suitable for the columns of this journal.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, OCTOBER 10th.

DERMATOLOGICAL SOCIETY OF LONDON (11 Chandos Street).—5.15 p.m.: Meeting.

HUNTERIAN SOCIETY (London Institution, Finsbury Circus).—8.30 p.m.: Hunterian Lecture:—Dr. J. K. Fowler:—The Diagnosis and Treatment of Thoracic Aneurysm.

POST-GRADUATE COLLEGE (West London Hospital).—10 a.m.: Diseases of the Throat, Nose, and Ear. Diseases of Children. 2 p.m.: Medical and Surgical Clinics. X-Rays. 2.30 p.m.: Operations. 4.30 p.m.: Lecture:—Mr. C. B. Keetley: Opening Address of Winter Session.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC.—4 p.m.: Mr. A. H. Tubby: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. H. L. Jones: Rodent Ulcer and its Treatment by Zinc Ions.

THURSDAY, OCTOBER 11th.

BRITISH GYNÆCOLOGICAL SOCIETY (20 Hanover Square).—8 p.m.: Specimens will be shown by Mr. F. B. Jessett (President), Dr. H. Macnaughton Jones, and Dr. H. Overy.

HARVEIAN SOCIETY OF LONDON (Stafford Rooms).—8.30 p.m.: Papers: Dr. A. Morison: The Cardio-Vascular State in Asphyxia Neonatorum and its Management. Mr. H. T. Herring: Easy Methods of Sterilising Urethral Instruments.

NORTH-EAST LONDON CLINICAL SOCIETY (Tottenham Hospital, N.).—4 p.m.: Address:—Sir Halliday Croom: The Obstetrical and Gynæcological Relations to Exophthalmic Goitre.

POST-GRADUATE COLLEGE (West London Hospital).—2 p.m. Medical and Surgical Clinics. X-Rays. 2.30 p.m.: Operations Diseases of the Eye. 5 p.m.: Lecture:—Practical Surgery.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC.—4 p.m.: Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m.: Lecture:—Dr. C. Mercier: Some Aspects of Drunkenness.

FRIDAY, OCTOBER 12th.

CLINICAL SOCIETY OF LONDON (20 Hanover Square).—8.30 p.m.: Address:—Mr. H. H. Clutton (President): Adolescent (late) Rickets (illustrated by lantern slides and cases). Followed by a discussion.

POST-GRADUATE COLLEGE (West London Hospital.—2 p.m. Medical and Surgical Clinics. X-Rays. Diseases of the Throat, Nose, and Ear. 2.30 p.m.: Operations. Diseases of the Skin. 5 p.m. Lecture:—Surgical Cases.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC.—4 p.m. Dr. St. Clair Thomson. Clinique. (Throat.)

NATIONAL HOSPITAL FOR THE PARALYSED AND EPILEPTIC (Bloomsbury).—3.30 p.m. Clinical Lecture:—Dr. Beevor: Cerebral Anatomy and Localisation.

SATURDAY, OCTOBER 13th.

POST-GRADUATE COLLEGE (West London Hospital).—10 a.m. Diseases of the Throat, Nose, and Ear. 2 p.m.: Medical and Surgical Clinics. X-Rays. 2.30 p.m.: Operations.

Vacancies.

Kent and Canterbury Hospital.—House Surgeon. Salary £90 per annum, with board and lodging. Applications to the Secretary.

Sheffield (City of).—Visiting Medical Officer for the Schools under the control of the Education Committee and Assistant Medical Officer of Health for the City. Salary £400 per annum. Applications to H. Sayer, Town Clerk, Town Hall, Sheffield.

Sussex County Hospital, Brighton.—Senior House Surgeon. Salary £100 per annum, with board and residence, and washing in the Hospital. Applications to the Secretary.

Nottingham City Asylum.—Junior Assistant Medical Officer. Salary £150 per annum, with apartments, board, &c. Applications to the Medical Superintendent.

West Suffolk General Hospital, Bury St. Edmunds.—House Surgeon. Salary £100 per annum, with board, residence, and washing. Applications to John H. Bonner, Secretary.

Kidderminster Infirmary and Children's Hospital.—House Surgeon. Salary £120 per annum. Applications to the Secretary.

The Stamford Hill and Stoke Newington Dispensary.—Junior Resident Medical Officer. Salary £100 per annum, with apartments and board. Applications to the Senior Medical Officer, 189 High Street, Stoke Newington, N.

Somerset Hospital, Cape Town.—Assistant Resident Medical Officer. Salary £200 per annum, with quarters and rations. Applications to David and Soper, Agents to the Somerset Hospital, Cape Town, 54 St. Mary Axe, London, E.C.

Manchester Royal Infirmary and Dispensary. Honorary Assistant Physician. Applications to the Chairman of the Elective Committee, on or before October 31st. (See advt.)

Appointments.

BAILIE, H. W., L.R.C.P. and S.Edin., L.F.P.S.Glasg., Superintendent Medical Officer of Health of Belfast.

BERGIN, FRANK GOWER, L.R.C.P.Lond., M.R.C.S., House Surgeon at Bristol General Hospital.

EDWARDS, ALBERT DAVIES, B.Sc.Lond., L.R.C.P. and S.Edin., L.F.P.S.Glasg., L.S.A., Resident Medical Officer at the Cardiff Workhouse.

ESKELL, LOUIS BENJAMIN, L.D.S.Irel., Honorary Dental Surgeon to the Winsley Sanatorium.

GREEN-ARMYTAGE, V. B., L.R.C.P.Lond., M.R.C.S., Casualty Officer at the Bristol Royal Infirmary.

MACDIARMID, R. C., M.B., M.S.Glasg., D.P.H., Certifying Surgeon under the Factory and Workshop Act for the Alyth District of the counties of Perth and Forfar.

MORRIS, LEONARD NEWSOM, L.R.C.P.Lond., M.R.C.S., House Physician at the Bristol General Hospital.

PINNIGER, WILFRID JAMES HUSSEY, M.B., B.S.Lond., L.R.C.P Lond., M.R.C.S., Casualty Officer at the Bristol General Hospital.

SHAW, ERNEST H., M.R.C.S., L.R.C.P.Lond., Casualty Officer, Pathologist, and Registrar to the Metropolitan Hospital.

SMITH, FRANCIS SHINGLETON, M.C.Cantab., L.R.C.P.Lond., M.R.C.S., House Surgeon at the Weston-super-Mare Hospital.

STORRY, JAMES ALEXANDER, L.R.C.P.Edin., L.R.C.S.Irel., Medical Officer to the Dunstable and District Joint Isolation Hospital.

SYKES, ARTHUR, L.R.C.P.Lond., M.R.C.S., Resident Medical Superintendent at the City Asylum, Norwich.

WILSON, M. R. O., L.R.C.P.Lond., M.R.C.S., Assistant House Physician at the Bristol General Hospital.

Marriages.

FORSYTH—BURN-MURDOCH.—On Oct. 5th, at St. George's, Charlotte Square, Edinburgh, Noel Constable Forsyth, M.B., son of J. Forsyth, Esq., Quinish, Mull, to Dorothea, daughter of T. M. Burn-Murdoch, Esq., F.R.C.P.E., 14 Charlotte Square, Edinburgh.

Deaths.

CHILCOTT.—On Oct. 6th, at Highgate, Isabel Mary, dearly-loved wife of Arthur Chilcott, M.D. (Medical Superintendent St. Panoras Infirmary). Aged 36.

RAMSEY.—On Aug. 23rd, at Prahran, Melbourne, of pneumonia, John Ker Ramsey, M.D., of Prahran, aged 66 years.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIII. WEDNESDAY, OCTOBER 17, 1906. No. 16.

NOTES AND COMMENTS.

Compensation for Workmen.

AMONG the many delicate positions in which medical men find themselves placed, the treatment of injured workmen is one of those demanding the greatest circumspection. There are, unhappily, needy solicitors who are only too ready vexatiously to put into motion the Employers' Liability and the Workmen's Compensation Acts, and medical men have to be wary lest they become the dupes of these enterprising attorneys. A County Court case heard at Southwark last week, in which a workgirl sued her employers for permanent damage to her finger, called forth from the judge some caustic remarks on the way this injury had been treated. There was a decided conflict between the medical evidence for the plaintiff and for the defendant, and the judge took the view that the defendant was in the right. After the injury the girl attended St. Bartholomew's Hospital, where a piece of steel was extracted from the finger, but she subsequently went to a private doctor, who appeared in due course to give evidence for her. The house-surgeon, who was called by the defence, alleged that a statement made by the medical men who appeared for the plaintiff to the effect that the finger was lengthened by five-eighths of an inch, was not the fact, and he even went so far as to say that it was owing to the unskilful treatment of the finger that it became thinner and looked longer. He averred that the pain the girl felt and the inability to move her finger were due to suggestion, hysteria, or fear, and needless to say the judge, taking this view, commented adversely on the plaintiff's medical advisers.

The Moral of it all.

Now here was a case, if ever there were one, in which a previous consultation between the medical men engaged on either side should have decided the matter one way or the other without appeal to Court. A finger either is or is not five-eighths of an inch longer than another, and a tape-measure would have settled the point in two minutes. Moreover, the graver question whether the finger was permanently injured, or whether the girl was merely neurotic, could no doubt have been cleared up at a meeting of the professional advisers of either side. In a word, the point was capable of decision on medical grounds, and with conflicting medical testimony no judge or jury could have decided it. If after consultation the point remained in doubt, the judge could have called in the surgeon attached to his district. But County Court judges have an insuperable objection to doing so, and consequently we find the severest censure passed on two doctors in open court on the evidence of a third, without anyone being in a position to decide who was right and who was wrong. These incidents are highly unfortunate.

P.M. Room Fiasco.

THE halfpenny paper furore over the Cardiff *post-mortem* room attendant has fizzled out ignominiously. The Health Committee of the Corporation properly ordered an investigation to be made as to the cause of the wild assertions made about the caretaker opening bodies at *post-mortems*, and Dr. Walford, the Medical Officer of Health who was appointed to make inquiries, reported that the man was given a good character by the practitioners for whom he worked, and that everybody found he was competent and diligent. The only thing recorded against him was that an assistant to one of the medical men in the town, who went to make an autopsy, on one occasion found the lungs already removed from the body. This, as Dr. Walford pointed out, was probably the result of a slight excess of zeal, and the attendant promised not to repeat the performance. One of the councillors, who seems to have been at the bottom of the affair, consequently looks rather foolish, and it may be hoped he will be more careful as to his facts before making a hubbub in the future. If anybody really wishes to discover a scandal in connection with mortuaries, we recommend to his notice the highly improper practice, prevalent in more than one district, of the coroner's officer pocketing the shillings from the doctors' guineas, and the equally reprehensible one of mortuary attendants putting difficulties in the way of practitioners who have to do *post-mortems*, till half-a-crown is produced for their benefit.

Derby Guardians and Vaccination Officer.

IT is highly regrettable that pro-vaccinationists and anti-vaccinationists cannot agree to differ in a philosophical manner; the subject of the protection of children from small-pox is far too grave a question to be made the shuttlecock of contending factions in local politics. As it is, certain magistrates hav

shown to a rather unwise degree the indignation that intelligent men naturally feel at the unreasoning prejudices of anti-vaccinators, and consequently have drawn official remonstrance from the Home Office on their heads. The anti-vaccinationists, on their side, are trying to strain the law in their favour, and the Derby Guardians last week entered on a piece of folly likely to be still more sternly visited. These administrators of the law were called upon to appoint a vaccination officer, and they made it a conditon of his appointment that he should not without their consent take proceedings against defaulters. Now as this duty of instigating prosecutions lies with the Local Government Board, this condition is patently *ultra vires*, and therefore not worth the trouble of making. The Local Government Board are not likely to abrogate their duty in favour of the Derby Guardians, and we expect soon to hear that there is trouble. The interesting fact about vaccination is that since the conscientious objector appeared on the scene in 1898, the numbers of successful primary vaccinations have steadily gone up.

LEADING ARTICLE.

MEDICAL INCOMES.

IT is one of the more hopeful signs of the times that the public press has taken up with some energy the question of what they term "doctors' incomes." For some time past the subject has enjoyed a recurrent prominence among newspaper topics. For various reasons the education of the public in this way is one to be encouraged, not less in the interests of the medical profession than in those of the community. Obviously it is of the utmost importance that the nation should be supplied with competent and honourable medical men. Moreover, it is an essential condition of the maintenance of those desirable qualities that there should be a reasonable prospect of making a livelihood from the practice of medicine. In other words, the legal creation of a highly qualified medical practitioner connotes the necessity of protecting him against illegal and unfair competition. In the correspondence above alluded to, "clubs and chemists" take a prominent position. With regard to clubs, it must be admitted that the unfair competitors come from within the ranks of the profession. It is difficult to determine the best plan of dealing with men who are ready to give their services at nominal fees and to resort to any trick in order to secure a patient. The General Medical Council has interfered in the case of medical aid societies, which make a profit out of the services of a salaried medical man. If the Council by any subtle extension of their specific powers could exercise a similar disciplinary control over the ordinary medical club, they would confer a great boon upon the profession. In his recent address, Dr. McAlister showed how the Council had in some cases created its own powers. Apparently it is only when asked to take such steps as the increase of direct representatives, of a one portal system of qualification, or of reform of the Council and of the Medical Acts that the Council plead *non possumus* with one accord. As regards the matter of unqualified prescribing, the competition of chemists has long since passed into the region of established scandal. The evil wrought upon medical men thereby, and the gross wrong inflicted upon the public, are no less deplorable than disastrous. The extent of this form of charlatan practice it is not easy to estimate, but in the aggregate it may safely be described as enormous. The plea of the chemists that they prescribe only in simple cases is futile. Who is to decide what is or is not the "simple" case? As every experienced medical man knows, it is precisely the trivial symptom that often affords the key to grave underlying disease. Take as examples the dyspepsia of early phthisis, the headache of refraction errors, or the mixed and manifold group of acute inflammatory conditions of gout, rheumatism, and allied rheumatoid states. Indeed, it may be stated generally that the recognition of the significance of minor ailments is one of the lessons that come late in the experience of the medical practitioner. The chemist, on the other hand, being trained merely in the nature and handling of drugs, is absolutely incapable of the proper differentiation and analysis of symptoms. To him all affections of the scalp, for instance, represent ringworm; all headaches, no matter whether due to anæmia, toxic disturbance, gross cerebral lesion, or errors of refraction, suggest to his mind some symptomatic remedy such as phenacetin or antipyrin. Scabies is often treated by him as eczema, and early pneumonia as "a touch of bronchitis" demanding a cough mixture in nine cases out of ten liberally charged with narcotic drugs; serious heart trouble is met with bismuth and pepsin, administered to relieve the attendant gastric symptoms; while failing cardiac compensation is unrecognised. Some day an enlightened public and an enlightened legislature will doubtless assess at its proper value unqualified prescribing of all kinds, and will take steps to confine medical practice to the legally qualified. Although any limitation of the kind would clearly be to the benefit of the medical profession, it would be a thousand times more economically valuable to the nation in the saving of life and limb that must be the inevitable result. The present stringent rules that guide, govern, and control the education and qualification of the medical practitioner are justified by the plea that they are demanded for the protection of the public. In spite of the recent jeremiad of the President of the General Medical Council, we venture to submit that the safety of the man in the street would stand on incalculably safer footing were he also protected against the machinations of quack prescribers, quack medicine vendors, and quack practitioners, and were the duty of suppressing illegal practices of the kind conferred upon the Council.

NOTES ON CURRENT TOPICS.

Sir Lambert Ormsby on the Medical Services.

The Opening Addresses at the various hospitals offer year by year good opportunities for instructing the public on certain matters regarding which medical opinion is valuable. Sir Lambert Ormsby acted wisely, therefore, in his address to the students of the Meath Hospital, in discussing some of the points wherein the medical services are still at fault. While admitting freely the great improvements which have taken place in the Army Service during the past few years, he drew attention to the several causes which have in recent years brought the Senior Service into unpopularity. It is necessary that, unless the Naval Medical Service is to pass into the disrepute until recently possessed by the Army Service, steps be quickly taken to remedy the grievances under which naval surgeons suffer. As the Service stands at present there is much reason for Sir Lambert Ormsby's advice to young medical men to avoid the Navy as a career. As regards the administration of the Medical Service of the Army, Sir Lambert Ormsby emphasised the absurdity of the present position in that the Adjutant-General, a military officer, is the head of the sanitary and hygienic department of the Army. The Director-General is merely a subordinate, whose representations may be passed over without anyone being the wiser. If the sanitary service of the British Army is to keep level with that of other countries, it is absolutely necessary that a skilled sanitarian should be at its head, not merely with information to know what is necessary, but with power to carry his plans into practice. It is well that the public should be fully impressed with the fact that the mortality of war has been in most cases a mortality of disease and not of wounds, and has been therefore a preventable mortality. The care of the health of the soldier is the first necessity of a successful campaign, and it is essential, therefore, that the officer charged with that care should be fully responsible, and, in his own department, supreme.

Consumption in Ireland

Mr. McArdle has done a good service in the fight against consumption in Ireland by his stirring address at the opening of the session at St. Vincent's Hospital. He has been able to attract public attention to one of the most serious problems affecting Irish life at the present day, and we cannot but believe that when once the public realise the gravity of the problem, nothing will be allowed to stand in the way of its solution. Last year 11,882 people, mostly young men and women, died from tuberculous diseases in Ireland. If the public can be made to realise that that mortality is, in the main, preventable, then we are sure the community will fail in nothing which tends toward prevention. Mr. McArdle went on to point out some of these methods, and in particular he urged the establishment of a dispensary for consumptives in Dublin. This dispensary would undertake the treatment of consumptive patients, would instruct them in the methods of preventing the spread of the disease, and would when necessary follow them to their homes, and safeguard the health of their friends. It would, of course, be equipped with all necessaries for the diagnosis and modern treatment of all forms of tuberculous disease, and it would have a strong and competent medical staff. Mr. McArdle's suggestion has been well received by the press, and it rests to a great extent with medical men to keep the project well to the fore.

Hospital Staffs and Outside Visits.

As a rule, the man in the street utterly fails to regard the medical charities from an economic point of view. To his mind, those institutions exist for the relief of sickness and bodily suffering of all kinds, and he refuses to recognise the rights of the medical profession in asserting a prior claim upon those who are able to pay proper fees for medical services. Last week, his eccentric habit of mind was brought into grotesque prominence at a London inquest, where bitter complaints were made because the Westminster Hospital would not send out one of their medical staff to see a man in a neighbouring office who had suddenly collapsed from heart failure. An account of the case will be found in another part of the present issue. It would, indeed, be the last straw upon the already intolerable burden of hospital competition were the medical charities to allow their resident or consultant staff to visit sick persons outside the hospital walls. It will be fresh in the minds of readers that some of the Charing Cross Hospital house surgeons and house physicians visited the scene of the recent accident at the adjoining railway station, where the fall of the roof killed a number of persons. Very rightly, as we think, the attention of local medical men was called to the innovation, which was generally condemned as unwise even in the face of so grave a disaster.

Royal College of Surgeons o England.

At a quarterly meeting of the council, held on Thursday, Mr. Henry Morris, president, in the chair, the report of the council to be presented to the annual meeting of Fellows and Members of the college on November 15th was approved and adopted. During the year with which the report deals the following diplomas have been issued:—Membership, 423, Fellowship, 42, Licence in Dental Surgery, 87, and Diploma in Public Health, 33. During the past year the library has been open 271 days, and the number of readers has been 11,267. The deaths of 20 Fellows and 264 Members of the college have been reported. An honorarium of £100 was presented to William Pearson, the prosector in the museum of the college, "in recognition of his valuable work and of his having completed 50 years in the service of the college." It was decided to publish a revised edition of Part I. (Man) of the Osteo-

logical Catalogue. The loan of museum specimens to the Army Medical Department for examination purposes was renewed for another year. Mr. G. A. Walker, until lately a student at Epsom College, and now at the London Hospital, was nominated by the council as the fourteenth Jenks scholar.

Side-Lights on Medical Education.

WE have commented more than once on the misleading nature of the figures published from time to time by one of our contemporaries under the title "Side-lights on the Medical Profession." These figures, extracted with variable degrees of accuracy from the returns of the examinations for the different Service examinations, are supposed to give some information as to the quality of the education supplied by the different medical schools of the kingdom. That conclusions arrived at on such data are liable seriously to mislead the public was well exemplified by the letter addressed by Dr. Ryan, a graduate of the Royal University, to the *Irish Times* last week. The avowed intention of this communication was, from a quotation of the figures referred to, to depreciate the reputation of the medical degrees of Dublin University, as compared with the qualifications granted by other bodies. Unfortunately for Dr. Ryan's contention, Professor Dixon was able to show in a letter to the same paper that, whereas prior to 1905 the Royal University stood second to the English universities in the percentages of candidates qualified and commissions won, during the last two years Dublin University has headed the list of universities of the kingdom. Moreover, Dr. Dixon is also able to state that about half of the successful Royal University candidates in recent years had been members of the Dublin University Service Classes. We do not ourselves regard the Service figures as sufficient data for any conclusion as to the education given at the different schools, and we think it unfortunate that an attempt should be made to use such untrustworthy weapons to attack the reputation of an ancient and liberal seat of learning.

"Prejudice and Ignorance."

IT is one of the results of the campaign of inuendo and vituperation conducted against hospitals by certain people who profess and call themselves humanitarians, that the poor conceive the idea that these beneficent institutions are laboratories for surgical experiment on helpless patients. People who prate on platforms and bluster in the correspondence columns of the press—to their own magnification—might possibly reconsider their actions if they were brought to hospital wards or the cottages of the poor and heard the house-surgeon or general practitioner pleading with ignorant and prejudiced parents for the life of a child. "We don't want 'im cut about," and "We ain't going to 'ave 'im experimented on by the doctors"—these and such phrases as these are among the commonplaces of practice among the poor. Medical men know well enough whence these ideas come, and they know how difficult it is to overcome them. At an inquest recently held at Hampstead by Mr. Schroder on a child who died of meningitis, the mother said she had taken him to the Hampstead Infirmary, but would not let him be taken in as an in-patient. A doctor was called in later and advised that the child should be sent to hospital to be operated on if necessary. Again the parents refused, in spite of the doctor's entreaties that the patient should be placed under skilled observation with a view to operation. After hearing the evidence the jury returned a verdict in accordance with the medical evidence, and added that in their opinion death was accelerated by the parents' neglect to follow the doctor's advice, and that such neglect was due to prejudice and ignorance. We would that this finding could reach all those who delight to villify hospitals.

Bond Street, Beware!

PEOPLE who deal in unqualified medical practice play with edged tools, and sooner or later they generally come to grief. "Beauty Doctors" are the craze of the moment, and with straps, ointments and washes the only harm they are likely to do is to impoverish the vain, insipid creatures who resort to them for advice. But when it comes to special treatments, the removal of hairs, massage of the face, and blowing steam on to the skin, there are potentialities of physical damage which they are foolish to risk—as their patients are to submit to. An amusing case has just been tried in New York in which poetic justice was visited on the folly of a beauty patient. The lady in question was the wife of a fashionable dentist, and, being afflicted with "superfluous hairs," *alias* a moustache, she attended at the saloon of a "beauty doctor" in Philadelphia for treatment. The latter apparently was foolish enough to use carbolic acid for removing the hairs, and the patient was severely burned about the face. Indeed, she so far lost whatever remnants of good looks she had previously, that her husband lost what remnants of love he had for her, and he gaily entered on an illicit liaison with a school-teacher. The wife, having lost her complexion before, now lost her temper; indeed, she went so far as to horsewhip the interloping mistress. But the husband's attentions continued unabated, and finally divorce proceedings were instituted against him, and an action for loss of her husband's affection against the "beauty doctor." But during the trial of the latter suit a reconciliation took place between husband and wife, and the former was able to testify that it was all through the "beauty doctor" that they had been estranged. If every woman who was disappointed in her beauty-treatment sued the amateur doctor in whose hands she was, we fancy several shutters would go up in several well-known establishments.

Medical Motoring.

At Gloucester Petty Sessions last week a local medical man was fined £1 and costs for driving to the danger of the public on a certain date. The speed was stated to have been twelve to fourteen miles an hour, a dangerous rate for crowded thoroughfares, where the offence was committed. The defendant stated that his steering gear had gone wrong, so that he was not able to control the motor properly. The question of speed is one of growing importance all round, and now that motors are being widely adopted by medical men it has an increasing professional interest. If a motor be defective it is certainly unwise to drive it through any streets or roads, be they in town or country, for there is no more dire and disastrous Nemesis than that which sits behind such a car. Any medical man availing himself of this species of locomotion should become familiar with every part of the machinery, so that he may instantly detect any departure from the normal. Under proper management a motor is simply invaluable to any medical practitioner in busy practice, more especially, of course, to those who habitually cover long distances.

Juvenile Criminals.

All medical men interested in criminology will regret the retirement of Mr. Legge from the post of Chief Inspector of Reformatories and Industrial Schools, especially when they read his last report which has just been issued. For in it they will see that these schools and institutions, which are of the highest value to the country, have been under the guidance of an enlightened and sympathetic administrator, and of such there are all too few in the higher ranks of the Civil Service. In spite of the improvements in these schools which have taken place in the last few years, the fact that a vast amount remains to be done is patent, for not only is the number of convictions of young people for indictable offences on the increase, but, what is more disappointing, the number of reconvictions in England is so also. Mr. Legge deplores the apathy which pervades authorities with regard to the use of truant schools and to committals to industrial schools, for, as he points out, good, far-reaching and permanent results are only to be expected if a sound and prolonged probationary period is enforced. It is not to be wondered at that difficulties are encountered in placing these juveniles, who start out in life under a cloud, in suitable employment, and that they are not particularly welcomed. Many of them, of course, are abnormals and can never be expected to fill normal posts in society, and it is a pity that special colonies cannot be founded where under supervision they might do good service. At present the bad ones encumber the opportunities which would otherwise be open to those who have recovered from the early stigma, and it is difficult for the latter to have a fair start. Even the mercantile marine, which provided a promising career for many, is becoming closed to the industrial and reformatory boys who are trained on special ships for a seafaring life, and the naval authorities give them no encouragement. Preventive psychiatry, if the term may be allowed, is a branch of preventive medicine that must come more and more to the front as society becomes better organised and more fully aware of its responsibilities.

Servants' Bedrooms.

Much is heard nowadays about the advance of sanitation; correspondingly little is heard of its absence from the modern servant's bedroom. On this matter it is impossible to write too strongly. We say deliberately that the bedrooms provided for servants in many modern flats we have visited are unfit for human habitation. They are frequently so dark that gas or electric light has to be used all day; some have no ventilation except a window opening into a passage; and most of them are so small that it is impossible for the servant to get anything like an adequate quantity of air. If such rooms were provided in workmen's dwellings they would certainly not be passed by the medical officer of health, but being provided in flats rented at anything from £50 to £500 a year, presumably they do not come under the ken of the health department. Landlords apologise for want of light by saying that the servant only sleeps there, but it is noticeable that many of the kitchens are equally dark and insanitary. Young girls who are put into these ghastly traps become anæmic and sallow, and either contract tubercle and die, or live to be the weakling mothers of puny, rickety families. It is a platitude to assert that no room should be occupied by human beings which has not openings for the entrance and for the exit of air and which does not permit of the sun's rays reaching every corner, but it is equally a platitude to say that these considerations carry no weight whatever with the proprietors of many modern London flats. The new clauses of the Housing of the Working Classes Act, 1903, must surely be applicable to such buildings as these, and medical officers of health and all who value the health and happiness of this generation and the next should combine to have closing orders enforced against these barbarous and pestilential dungeons.

Sir Francis Laking, Bart., Physician in Ordinary to His Majesty the King, was sufficiently convalescent to be removed last week from his London residence to the Isle of Wight.

Dr. John Cameron, of Liverpool, who died a few weeks since at the ripe age of eighty-eight, has left by will property to the value of £54,400, of which he bequeathed £1,000 to the Royal Southern Hospital, Liverpool. Dr. Cameron was for fifty years a contributor to this journal.

On Saturday last the Regius Professor of Medicine, Dr. Osler, opened a new wing at the Acland House, Oxford, erected in memory of the late Mrs. Acland and Sir Henry Acland, for many years President of the General Medical Council

A CLINICAL LECTURE

ON

THE THERAPY OF BASEDOW'S DISEASE.

By PROFESSOR SCHLESINGER, M.D.,

University of Vienna.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

IT has occurred to me that a subject of such supreme importance as exophthalmia, a disease affecting the throat, heart, eyes and nervous system, would not be without interest to medical men, even though it were only to recapitulate the prominent features of the disease; but the treatment of such an obscure disease is of greater importance still. In offering advice to the profession it is necessary to commence with the early symptoms of the disease.

In the early stage of Morbus Basedowii a variety of phenomena make their appearance, but the most important for the physician is the rapid and persistent loss of body weight; even several kilogrammes may be lost before any suspicion of a neoplasm flashes across the mind of the attendant. Such events are not uncommon in daily practice, and cannot be too often repeated to be of use in our daily vocation; even the cardiac symptom associated with emaciation may be neglected as the preliminary warning to the succeeding disaster.

Supposing we have diagnosed the disease at this early period, our duty is to arrest its progress if possible. Drugs such as thyroid gland, ovarian tabloids, or iodide preparations will not give immediate relief, nor is this so available at this stage of the disease as a modification or correction of diet and habit. First of all prohibit smoking and drinking; if the latter must be retained let it be moderate, in small quantities of beer. All gaseous foods, or foodstuffs likely to produce flatus, should be forbidden, and with this principle in view every form of milk diet should be encouraged. The open-air rest cure is as true in this disease as in tuberculosis, and should be enjoined in some form. The hydropathic treatment must be proceeded with carefully if prescribed at all; and should not extend beyond luke-warm baths with cold effusions to the neck by means of a sponge or towel. It would be better to commence with separate parts of the body, gradually increasing the area till Shepmann's douche could be applied to the spine with tepid water. When the heart is painfully throbbing, the application of some cold object such as a cold-water bottle of india-rubber, aluminium, lead, or vulcanite. Winternitz is strongly in favour of the hydropathic treatment on the ground that it improves the appetite and hastens metabolism. It has proved successful in Winternitz's hands, but it must be undertaken with great care. Galvanisation may be commenced later, with suitable medication. It often happens that a combination of these remedies has more effect in relieving the patient than any single course, however rational it may seem to the physician. Though bathing, for instance, is dangerous, yet it will give instant relief to the vexatious feeling of heat. The great weakness and danger of sudden collapse are the first objects of care, while complications increase the difficulties. Anything, therefore, that will allay pain, improve the appetite, increase metabolism, and add to the body weight should be the aim of the attendant. All observers agree that the increase of body weight is a good measure of improvement, indicating the close of the acute stage.

The acute stage is sometimes doubted in Morbus Basedowii, or presumed to be an accident, but within the last two years I have had occasion to record four of these. Commencing with three or four tablets of the ovarian gland has a wonderful calming effect on the acute condition.

During a single year so many remedies have been prescribed for the cure of Basedowii that the half of them are now forgotten, and will probably never be heard of more. There is one opinion dominant that the disease has its origin in the thyroid gland, while Mœbius has declared from the beginning and maintained that it was due to a hyper-secretion or excited activity of the gland. Whatever the theory of causation, two hypotheses are accepted in the treatment—viz., that the system is injured in some way by the altered function of the gland; and a portion of the gland or morbid part of it should be removed to cure the patient, but experience proves the latter to be fraught with difficulty and danger.

The first indication would be to neutralise the poison, and to effect this Lanz fed his patients on goat's milk whose thyroid gland had been removed in the hope of neutralising the hyper-secretion in the diseased gland. Lanz has put on record some wonderful cures by this treatment, which seems logical, as it certainly must deprive the blood of the irritant that increases the gland. This form of treatment led to a powder of milk being put on the market under the name of "Rodagen," which supplied the principle conveyed by the thyroid-ectomised goat's milk. The necessary quantity of goat's milk was ¼ to ½ of a litre, and the corresponding dose of "Rodagen" was one to two grammes daily; larger doses were not easily borne by the stomach. My own experience of this powder was not so favourable as literature painted it. During the last year I have used the milk of thyroidectomised goats both in hospital and private practice for months together with fairly good results. The treatment is not curative in action, but ameliorative. The patient is certainly generally improved, but the Basedowii symptoms still remain unchanged. Another practical difficulty in the treatment is the short time that the goat gives milk after the thyroid gland is removed, often disappearing in a few weeks after the operation, also is always reduced in quantity after removal. Last year we had to remove the thyroid from three goats in two months to supply three Basedowii patients with

the necessary amount of thyroidectomised milk, but our supply running out left us without results. Rhodagen is a preparation so expensive, and in my opinion so inoperative, that I cannot recommend it, although I have used a considerable amount of it. My own experience of the milk of thyroidectomised goats and Rhodagen is negative, and not worth further consideration.

The fashionable blood serum could not escape observation in this obscure disease! Sheep have had the gland removed and the serum applied subcutaneously to the patient with no better results. There is still a blood serum on the market under the name of Antithyroidin Mœbius, reputed for its efficacy in Morbus Basedowii, but there it ends. Mœbius reports many successful cures. I have used three to five grammes daily, gradually increasing to four and five grammes, with occasional periods of rest. I have also used it by the mouth, and given it warm in wine, which is more efficacious. In this way I have found the patients express themselves as very much better. The rapid pulse became less, the thyroid diminished, and the body weight increased. With all the preceding treatment there are often sequelæ, more fatal than the disease produced, which deserve careful attention, but in my own use of the sheep's gland by the mouth I have not observed a single adverse symptom, which is something to say in commendation of using the sheep's thyroid per os; but again I repeat that the price is not commensurate with the results where the case is chronic. In acute cases the thyroid might be, and is, administered with success, but where it is of long standing the benefits are slight.

We now come to the operative treatment, which has also gone through many transformations. Kocher recommends the removal of the morbid portion of the gland only, and prescribes certain methods of operation that are necessary. Then we have others recommending a combination of methods and tying the nutrient artery after partial excision of the struma, with no better success. All their statistics testify that we are no nearer curing the disease than when it was first observed, although an operation certainly ameliorates the symptoms, but the operation itself is fraught with danger, as the high mortality shows. Operating should only be advised where the cases are so bad as to disable the patients from following their respective duties, and after being fully informed of the dangers attending the operation. When the exophthalmia is severe, with obstinate keratitis and much impairment of health, associated with wasting and cachexia, and every drug has failed, operation may be prudently advised as the only course left for hope. Operating relieves many of the severe symptoms such as the exophthalmous and cardiac, and is worthy of trial in severe cases.

The injection of drugs into the gland itself has its admirers, but reports do not give us much confidence in that direction. The favoured drug is iodoform ether, which has occasionally met with some success.

The Röntgen rays applied directly to the gland has been practised by my second assistant with great success. Dr. Weidermann has treated five cases in this way with great promise; all of them increased in weight within a very short time, but the Morbus Basedowii conditions were in no way influenced. As soon as the application of the rays ceased, the patients began to emaciate and fall back into the former state.

Having given you the latest treatment with my own hopeless suggestions I shall now fall back on our earler procedure as the most satisfactory. The time-honoured hydropathic treatment does more to calm the heart and relieve the nervous irritation than any of our more recent novelties. Along with this may be combined the electric treatment in the galvanic form with great advantage. The current may be passed through the gland and sympathetic nerves by placing one electrode in front of the thyroid and another on the spine, or the poles may be placed on either side of the gland itself. Allowance must be made after repeating the treatment for the loss of cutaneous resistance, or you burn the patient severely. Although sceptical of electric treatment generally I must confess that I have seen the frequency of the pulse reduced and the gland diminish after a course of treatment of this kind. With even two or four celled baths I have seen most of the symptoms disappear—even the diarrhœa and palpitation.

Change of residence was once held as the primary feature in all treatment, and particularly to elevated localities — even mountains had specific virtues. I have had patients transferred to mountains over a thousand metres high who became very unwell; sleepless, palpitation, etc. The best results we can get from elevated positions are to be found in those who do not worry nor take long walks, but who rest, take their food well, and remain quiet and contented; these are often greatly benefitted by the change.

All of them, however, after a month's residence at home return to their former condition; therefore the hill hospice must be a permanent residence for Morbus Basedowii.

The opposite has also been pressed. Sea-side residence and sea-bathing has its votaries in this trying disease. The temperature should not be too low and the time of exposure short, not extending beyond a few minutes, as paralysis is easily induced when the shock is prolonged and the cutaneous surface stimulated. Sea voyages are beneficial, as the patient can sit on deck in fresh air and improve the appetite without undue exertion. A little walking exercise does no harm; it is forced walks where a constant strain is kept up that does the injury. Hence driving and touring should be encouraged, as change of scenery is of immense value to the patient.

I need hardly trouble you with drugs; reported cures are legion, but they have all failed in my own hands. I think it will be more profitable for me to relate the drugs that certainly do more injury than good. The first and most formidable of these is the thyroid gland, which probably will be the first drug offered. The history of this treatment proves that in initial cases when the thyroid is given the disease rapidly goes from bad to worse; hence the necessity of carefully guarding against fatal danger.

Ovarian preparations have no better history to relate. The case I have treated with them produced many complications that more seriously endangered the patient's life than if they had been avoided. The iodide preparations are equally dangerous, and their benefits very problematic

even in the best form they can be given. The thymus preparations are free from many of the dangers mentioned, but the results are very doubtful. Digitalis is another drug often prescribed, doing no harm and as little good except in feebleness of the cardiac muscle, but it has no influence on the tachycardia; in strengthening the muscle it is important.

I shall now enumerate a few of the drugs that may be given:—Phosphorus, arsenic, strychnia, quinine, and iron where anæmia is present.

Kocher speaks very highly of the use of phosphorus; his results are confirmed by many other investigators. I can vouch for more good being obtained from the use of phosphorus than any other drug. I usually prescribe half a milligramme in a pill, and give two daily. The same quantity of phosphorus may be given in cod-liver oil.

℞ Phosph., 0.01 gramme.
Jecor ascelli, or lipanin, 100 grammes.

This is well mixed, and two dessert-spoons given daily. A gramme or two of the phosphate of soda may be given daily with the same benefit. It might be noted here that lipanin is an emulsion of olive oil, 6 per cent., which has a better taste than cod-liver oil or jecor ascelli.

In the prescribing arsenic I have used for several years the cacodylates for their less poisonous properties. I am favourably inclined towards atoxyl as a subcutaneous injection: a ten to twenty per cent. watery solution injected intramuscularly twice a day. I have never seen intoxication with the drug when prescribed in this form. With natrium cacodylicum we are not so free from the danger of poisoning, but one to two centigrammes may be given by the mouth or intermuscularly without danger. There are other private preparations such as "Metharsinat," some of them perhaps good in their way, but giving off objectionable exhalations. In anæmia the ferrum cacodylicum may be given by the mouth, as subcutaneously it produces severe pain. The dose is one to two centigrammes per day, in the form of pill or watery solution.

Strychnia as a tincture may be given with quinine with great benefit The following pill is useful:—

℞ Ext. nucis vomici, 0.4 gramme.
Quin. muriatis, 1.5 grammes.
Ext. centauri, 2.0 grammes.
Ex. taraxici, q. s.
Fiant pilulae 50.

Signatur: Three pills to be taken daily.

In addition to these general tonics it may be necessary, in many cases, to soothe and calm painful symptoms. The foremost in this class of drugs is bromine. Any of the preparations may be used, but my own experience favours the following mixture:—

℞ Ammon. brom., 0.2 grammes.
Codeia phosph., 0.1. grammes.
Sodium brom., 1.0
M.

Signatur: One to be taken three times a day.

In conclusion, it may encourage us to persevere in our efforts with the knowledge gained during the last decennium, as I am yet hopeful of obtaining better results than we have secured in the past by adopting less dangerous methods with better success in the treatment of Basedowii.

NOTE.—*A Clinicol Lecture by a well-known teacher appears in each number of this journal. The lecture for next week's number will be by Francis J. Steward, M.B., M.S.Lond., F.R.C.S.Eng., Assistant Surgeon to ana Surgeon in Charge of the Throat Department, Guy's Hospital; Assistant Surgeon Hospital for Sick Children, &c., on "The Surgical Aspects of Tubercular Peritonitis." Lecture delivered at Guy's Hospital, May 25th, 1906.*

ORIGINAL PAPERS.

ACTINOMYCOSIS OF THE VERMIFORM APPENDIX. (a)

By THOS. H. KELLOCK, M.A., M.D.CANTAB., F.R.C.S.ENG.

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THE author first pointed out how much more frequently actinomycosis or streptothricosis, as the affection should be preferably termed, was recognised since more modern methods of examination had been employed. The affection, which was formerly expected to attack the jaws, liver, and lungs almost exclusively in persons whose occupations and lives were followed in the country, was now often recognised in many other parts of the body and in persons of various occupations and forms of life, town as well as country. The star or ray formation was not always present, and its absence must frequently have led to a negative diagnosis when the affection would have been recognised by proper staining.

As the fungus of streptothrix generally enters the body by the alimentary or respiratory tract, and has a great disposition to insinuate itself along the ducts of glands opening into these, it is easy to understand that the vermiform appendix should fairly frequently be attacked when the organism has travelled along the alimentary canal as far as the cæcum.

From the number of reported cases, actinomycosis of the vermiform appendix would appear to be a not very uncommon form of disease of that organ. An investigation of the records at the Middlesex Hospital showed that during the last three years seven cases had been under treatment in which the presence of a streptothrix had been demonstrated. The notes of two cases were read in which septic infection had been superadded to the streptothrix, in both of which portal pyæmia and streptothrix abscesses in the liver had been found *post mortem*, and in one a similar affection in the pancreas and pleura. In three cases the disease had been limited to the neighbourhood of the appendix, whilst in two this had been associated with an abscess presenting through the abdominal wall at some distance from the appendix region. A streptothrix infection of the vermiform appendix might thus be met with under two forms—the one simple, the other in which a septic infection had been superadded. In the first the condition is difficult to distinguish from an ordinary case of appendicitis, but in the second the patients were often extremely ill, and rigors and septic pyelophlebitis, both rarely seen in cases of ordinary suppuration about the appendix, seemed to be relatively common. These two forms of the affection were similar to

(a) Abstract of Paper read before the Medical Society of London, October 8th, 1906.

what is sometimes seen when the disease occurs in other parts of the body, such as the cheek. Attention was called to the tendency of the abscesses which form to burrow, and point at a distance from the original seat of the disease, and a comparison made to what often occurs in the same affection of the lungs.

The question was raised as to whether the so-called secondary streptothrix affections of the liver were really conveyed thither by the blood-stream, or whether they were not really an independent infection from the alimentary canal; in one of the reported cases the discovery *post mortem* of a streptothrix abscess in the head of the pancreas was quoted as an argument in favour of the latter view. The points that would be likely to be of help in arriving at a diagnosis in the simple cases would be a long history of slight indefinite pain in the region of the appendix, a relatively large amount of induration, and, if operation were performed, the small quantity of broken-down material found; in suppurating cases the occurrence of rigors early, and the pointing of abscesses at a distance from the appendix region.

The treatment should be both constitutional and local. In the simple cases the best results follow removal of the appendix and as much of the affected surrounding tissue as possible, combined with treatment by large doses of iodide of potassium. The suppurating cases are more serious, and little benefit is likely to be derived from the use of drugs until the septic condition has been dealt with by ordinary surgical measures, and it was pointed out how exactly this coincided with what is experienced in dealing with the affection as it occurred in other parts of the body.

TUBERCULAR CERVICAL GLANDS. (a)

By JOHN MARNOCH, M.A., M.B., C.M.,

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The recent enormous advances in Abdominal Surgery have led to the everyday performance in this domain of operations which are of absorbing interest both to operators and onlookers, and the result is that an amount of attention is now bestowed upon this department of surgery which twenty years ago was never dreamt of. Moreover, as a direct sequel, medical literature now teems with reports of operations, generally successfully performed, on almost every abdominal organ, for conditions and diseases which not so very long ago were left severely alone as being beyond the pale of surgery. However fascinating this field of work is, it has one drawback—namely, that it diverts attention from, and belittles the importance of, the surgical affections more frequently met with in practice.

Among these affections none is more common than enlargement of the neck glands from tubercular disease, and in some of its varieties none is more troublesome both to patient and doctor. The patience is tried, and in the case of the surgeon his operative skill as well.

Clinical Features and Indications for Operation.

It may be useful, then, to recall some of the clinical features of tubercular cervical glands and their surgical treatment, especially as the indications for operation and the best method of carrying it out, thanks mainly to the work of Watson Cheyne, have emerged from a somewhat chaotic condition, and may now be regarded as resting on a sound scientific basis. And yet it is very doubtful if these indications are as well known as they ought to be, for it is not an uncommon experience for cases to be sent to the surgeon that are either quite unsuitable for operation, or that have been allowed to drift into a state which prevents the best results being got from surgical treatment.

Before considering how glands which have actually become tubercular should be dealt with, some reference must be made to those enlargements which are dependent on irritation in the structures anatomically related to them. When one considers the large areas drained by the lymphatics of the neck, and how frequently inflammatory lesions are present in some of these, as, for example, in the mouth and throat, it is not to be wondered at if glandular enlargement takes place in the neck quite often apart from tubercular origin. But although this is so, it is of prime importance that these swellings should be carefully treated, for it is now well known that glands which enlarge primarily from this cause may later on become tubercular unless the source of irritation be removed. Whether the inflamed glands form a suitable nidus for the tubercle bacilli already in the bloodstream, or whether the organisms gain entrance at some breach of surface about the mouth or throat and pass on to the glands, is a debatable point. There seems to be considerable evidence in favour of the point put forward by Sims Woodhead—namely, that the tonsils and adenoid tissue of the throat are the first to meet the tubercle bacilli, and that if healthy they are capable of giving an account of a moderate number of the invaders, but that if they are debilitated by repeated attacks of inflammation they lose their powers of resistance and permit the organisms to pass on by the lymphatic vessels to the glands, in which they settle. Whatever the explanation may be, the fact remains, as already stated, that these inflamed glands may ultimately become tubercular. It behoves us, then, whenever cases of enlargement of the neck glands, especially in the earlier stages, present themselves for treatment, to make a thorough examination of the areas drained by the glands, and to remove every possible source of irritation. This is a point that cannot be too strongly emphasised, as it not infrequently happens that cases are sent up for operation upon the glands when what is really required is the removal of an offending tooth or hypertrophied tonsils and adenoids. Indeed, I have even seen treatment applied to the occipital glands which were swollen from the irritation of an eruption of the scalp. Early removal of the exciting irritation quickly causes these glands to subside and give no further trouble.

Turning now to tubercular glands, considerable confusion has arisen in connection with their operative treatment, mainly, I think, from the impression that in their case the indications were of a special and exceptional character. This is really not so, for if allowance be made for their exposed situation, the indications for operation are essentially the same as in most other tubercular diseases, as, for example, in joints. No one nowadays thinks of temporising with a joint which is the site of abscess or sinus formation. Fortunately, in the surgery of joints a more general recognition of the value of prompt operative interference under such conditions obtains; and yet when abscesses or discharging sinuses are situated in the neck, less compunction is often felt in leaving them alone. Why should a softening or broken-down gland be left to nature unaided any more than a suppurating joint? It is quite true that the joint affection is a more disabling thing than the discharging neck, for while a young adult with the latter can often continue at work, with the former he is obliged to lay up. The mere fact, however, of these gland patients being able to follow their occupation is no justification for leaving them insufficiently treated. Many of them at the expense of a week or two's work can by operation be put into an infinitely better state for their occupation than they were when kept below par by continuous discharge. Besides, the cosmetic result after operation is not to be compared with the puckered, drawn, irregular cicatrices of nature. The occurrence, then, of suppuration, with or without sinus formation, is the first indication for operative interference.

(a) Abstract of a Clinical Lecture delivered at the Aberdeen Royal Infirmary.

The next indication—namely, when the glands are causing deformity—is more peculiar to the neck on account of its exposed position. Generally speaking, when tubercular glands have become large enough to cause an unsightly tumour, softening has set in and quite frequently the inflammation has spread outside the capsules to the surrounding areolar tissue. This has the effect of obscuring the outlines of the individual glands by matting them together and at the same time rendering them fixed and immobile. But there is another way in which the outlines may be obscured and in which a bunch of glands feels almost like one tumour with a uniform even surface—namely, where they lie beneath the sterno-mastoid muscle. Here, of course, the glands are situated at a considerable depth, and the thick elastic muscle spread over them prevents the palpation of the individual glands and produces the ugly pig-like neck one so frequently sees.

The next type of case that requires operation is where the glands, although not large, are infecting those in the immediate neighbourhood. Such cases require close and frequent watching, and if sent away for climatic treatment must either be put under the care of a medical man near their residence, or, where this is not possible, be brought back at short intervals for examination. The reason is that tubercular glands of the neck are somewhat erratic in their rate of enlargement. While some gradually subside under general treatment, others may remain stationary for a time and then rapidly enlarge and infect others near them.

You will observe, then, that the cases in which operation is to be recommended group themselves into three clinical types: first, where there is suppuration or sinus formation; second, where deformity is caused; third, where the disease is progressive in character, fresh glands becoming infected.

EXAMINATION OF THE NECK.

The neck should be examined from two positions, namely from the front and from the back, and of the two the latter is the more valuable. Standing behind the patient one can ascertain by palpation the extent, consistence, and mobility of the glands, much better than from the front, and this method of examination ought never to be omitted in any disease of the neck characterised by tumour formation. The examination should be conducted also with the head in different positions so as to relax or make tense, as occasion requires, the various structures of the neck. Thus, in order to ascertain the full extent of glandular invasion, say in the anterior triangle, the head should be flexed, and it will be found that the fingers can feel deeply beneath the sterno-mastoid. On the other hand, a better idea of the consistence of the swellings can be got with the head in the extended position. Now, it is frequently no easy matter to be able to say whether glands are softening or not. One obvious reason for this is the depth at which they often lie. Then, again, softening may have taken place in the centre while the cortex is quite firm, and lastly, a whole gland may have completely liquefied but the intact capsule is so tightly distended that it closely simulates a solid gland. Experience, however, will enable you to recognise softening, and I should say that in any case where you are in doubt whether it is present or not, you will be pretty safe to conclude that it is. I would strongly urge you to palpate these cases in the wards before they come to operation, and then, after excision, to split the glands open and examine them for yourselves. I am sure you will often get a surprise by finding that glands which you thought were solid are in an advanced state of liquefaction.

From an operative point of view it is of considerable importance to ascertain whether the swollen glands belong to the superficial or deep set. At the upper part of the anterior triangle especially, a mass may appear to be quite superficial which has in reality deep connections. In such cases a good plan is to put the sterno-mastoid into action by asking the patient to turn the head to the opposite side, when it will be seen that the glands are projecting into the triangle from beneath the anterior edge of the muscle.

TREATMENT.

It is not the purpose of this lecture to deal with the general medical treatment, but some reference must be made to local applications occasionally used before operation is recommended. First, as regards the poultice. This is applied with different objects in view—some, indeed, diametrically opposed to each other. It is employed with the idea of allaying pain, and there can be no doubt as to its frequent efficacy in this respect, but pain is rarely a prominent feature of tuberculous lymph glands; indeed, it is seldom present. Then, again, a poultice is sometimes used with the idea that it will do either of two things: either it will cause absorption of the hyperplasia producing the swelling, or else it will hasten the occurrence and completeness of softening. There is certainly no proof that moist heat can do either, while on the contrary prolonged poulticing may unquestionably do harm by rendering the skin soft and sodden and thereby militate against good healing after operation. Fortunately in this disease the use of this homely remedy is on the wane, more especially in sinus formation, where, besides softening of the skin, a considerable area of eczema may be induced. Iodine also is another remedy used locally in the treatment of enlarged glands, and here, also, it is very doubtful whether any good result is got by its application to glands which have really become tubercular. When one hears of such local applications having reduced the size or caused the disappearance of swollen glands, it seems very probable that in this instance one has to deal with glands which are not tubercular at all, but which have become inflamed from some irritation in the area drained by them, and that the decrease in size is due to the subsidence of the irritation and not to the applications. The less these tubercular lymph glands are irritated by local applications the better. If anything is used it should take the form of some simple, comfortable splint which will both protect the glands and steady the head.

The ideal surgical treatment is complete excision, which should be carried out whenever possible. In order to get the best results both from a cosmetic point of view as well as from the point of view of eradication of the disease, the operation should be performed before suppuration has occurred, and certainly before it has extended beyond the capsules of the glands, or caused sinus formation. It should also be understood that periadenitis with its consequent matting adds materially to the difficulty of the operation, and indeed may render dissection impossible. The diagrams which are before you show the lines of incision for clearing out glandular enlargement in the various regions, and when the incisions are placed as they now are along some of the natural folds of the neck, the cosmetic result is exceedingly good. The operation is seldom one that can be performed quickly, for the deeper glands in the anterior triangle are invariably in close contact with the sheath of the internal jugular vein, and indeed often also adhere to it. To clear this area requires patient and careful dissection in order to avoid wounding or tearing the vein. When the glands are adherent to the sheath, the best and the safest way is to remove the adjacent part of the vein with the glands, a procedure that can be carried out with impunity. A structure which gets in the way and requires to be avoided is the spinal accessory nerve, which may lie on or run through the centre of the mass, but is not difficult to identify and can be lifted aside or dissected out.

While complete dissection is the ideal procedure, it must not be understood that it can always be done, and that scraping has no place in the treatment of this affection. The spoon may have to be employed in conjunction with complete removal by dissection or by itself. When there is a subcutaneous abscess, or when a softened gland bursts during removal, then the spoon is indispensable for getting rid of the softened material, after which dissection of the remaining glands is proceeded with. Then, again, when sinuses

have formed, these must be scraped out and disinfected before removal of the glands is undertaken. Scraping alone has to be adopted where there is extensive glandular invasion and matting, with here and there softening areas. It must be borne in mind, however, that one occasionally comes across cases belonging to this class where the scraping so causes the periadenitis to subside that subsequent complete removal becomes possible. There is one condition where you may be tempted to rely entirely on the spoon, and that is where apparently one gland alone is involved and has undergone softening. It cannot be said that this does not occur, but my experience is that usually in close relation with the softened gland, often behind it, are one or two smaller ones which are not detectable by palpation, but which must be shelled out after the softening one is dealt with, or else the patient comes back again in a few weeks with a recurrence of his disease in the same place. Then it should be remembered that a subcutaneous abscess frequently communicates through a small opening in the deep fascia with a cheesy mass lying below, and this also, as well as the more superficial pus, must be cleared away if good and rapid healing is to ensue. When the spoon is used, therefore, it must be employed very thoroughly, and the scraping should be vigorous, so as to ensure the clearing away not merely of the parts of the gland which have liquefied, but the solid parts as well; and in order to ascertain whether that has been accomplished or not, there is nothing better than the finger. If the capsule of the gland has been quite emptied, then it feels quite smooth; whereas if some of the glandular material still adheres, it is detected at once by touch as a roughening on the otherwise smooth surface. After a scraping operation, an excellent plan is to apply some pure liquid carbolic acid to the cavity, and then, in many instances, stitches can be employed and good healing result. Broken-down tubercular material, unless infected, is not septic like the pus of an acute abscess, and if it is all got rid of, healing by first intention is to be expected.

Drainage should be employed after operations on the neck, even in aseptic cases, more frequently than in other regions, as it is impossible to apply sufficient pressure by dressings and bandages to arrest the post-operative oozing, which, unless drained away, accumulates and gives rise to subsequent bother, or may even favour the occurrence of sepsis.

Such, then, is the treatment of tuberculous lymph glands, but even in complete dissection uniform success must not be looked for. Now and again a case dealt with apparently in the most thorough and satisfactory manner comes back again with a recurrence, and it is disappointing to have to tell the patient that another operation is necessary. Such recurrences are seldom serious, and the patient can be reassured by the fact that his second operation will not be so extensive an undertaking as the previous one.

THE FUTURE PROSPECTS OF THE MEDICAL PROFESSION. (a)

By Sir LAMBERT H. ORMSBY, M.D., F.R.C.S.,

Senior Surgeon to the Hospital, and Past-President of the Royal College of Surgeons of Ireland.

At the commencement of his address Sir Lambert Ormsby dealt at length with the past history of the Hospital, and the antiseptic theory of the treatment of wounds. He then continued:—

I now come to the second part of my address—

The Future Prospects of Your Profession.—You will ask me what are your future prospects. In answer I may mention the Navy, the Army, the Indian Medical Service, foreign appointments, ship surgeoncies, Irish Poor Law Medical Service, and lastly, private practice. Of these, I fear I will only have time to make a brief allusion to two. Some years ago I spoke at length of the favoured conditions of the home Army Medical Service as a career, and I am still in favour of this service, notwithstanding there are yet a few grievances to be remedied which I will now mention.

Last June there appeared in the London *Times* two important letters, one from Mr. St. John Brodrick, and this was followed by another from the pen of Sir Frederick Treves, Bart. From the lessons we learned in the South African campaign about the enormous number of men who died from disease compared with the fatalities from shot and shell, these letters should be read, marked, learned, and inwardly digested by everyone having the interest of the British soldier at heart, and if the Army Medical Department is to be further reformed the sooner it copies the wonderful organisation in every detail of our Japanese allies the better. Prevention, we are told, is always better than cure, but prevention of a disease in an army in the field is a matter of incalculable importance alike from the point of view of humanity, of duty, of efficiency, and of economy. In South Africa the deaths from wounds were 42 per thousand, while those from disease were 69 per thousand. The admissions to hospital were 34 per thousand from wounds and 746 per thousand from disease.

The *Times* says: "Let the public ponder the meaning of these enormous disease figures, and consider the gigantic waste of money they imply, to say nothing of the misery and permanent impairment of health suffered by large numbers of those who recovered."

Mr. Brodrick declares that the regulations of the British Service as to the prevention of disease remain substantially what they were a hundred years ago. Not so with the Japanese, who have done in ten years what we have not done in a century. Japan, in the war of 1894-5, had nearly seven sick for one wounded, and twelve men died of disease for one who died of wounds. But what do we find in their recent campaign with Russia, ten years later. They had very little more than one death from disease for every three from wounds.

We are told that the British "Tommy" will not respond to discipline the way the Japanese "Tommy" will, and we are told that during the Russo-Japanese campaign a whole column of men had marched for many miles in a hot parching sun, and the men literally dying with thirst (the contents of their water bottles having been long since exhausted); so good was the discipline in that army that coming to a large canal of water which was marked "contaminated" the order was given that they were not to drink a drop of this water, not a single man of the column fell out of the ranks or disobeyed the order.

What would the British soldier have done under the circumstances. I fear he would have said "my parching thirst has no law; I must drink, even if I am shot for it, or die from disease."

I wonder do the British public know that the present Director-General of the Army Medical Department is only a subordinate, and yet he is the responsible head of the health and well-being of every officer and soldier in the British Army! Could anything be more ridiculous and grotesque than that the so-called *head*, at present, of the sanitary and hygienic department of the Army, is the Adjutant-General—an officer probably absolutely ignorant of medical science in every respect. This officer is again under the control of a Secretary of State for War, who may not only be ignorant of medical science, but who may be one of a large class common even among leading statesmen, who think "doctors" should only be seen and not heard, and who scorn science in general, and distrust medical science in particular. This, however, does not apply to the present distinguished War Minister, Mr. Haldane, who, I am informed, is a most enlightened statesman, and one who is most anxious to improve every department of the Army. For two years the Director-General had direct access to the Secretary of State, and was present at the Army Council, with great advantage to the Army. The Esher Committee placed him again under the Adjutant-General, who happened to be his junior in rank. How can a man without special and technical knowledge properly represent a scientific department? If the cry for efficiency has any real meaning at all, the present Government of Progress, assisted by Mr.

(a) Introductory Address to the Winter Session in the Meath Hospital, 1906.

Haldane, ought to speedily place the present Director-General, Sir Alfred Keogh, K.C.B., an Irishman of marked ability and prudence, and a sanitarian of the first rank, at the head of his department, and also give him a seat on the Army Council, and invest him with such authority and responsibility as shall anticipate any catastrophe in a future war, and in some way endeavour to do away with the defects of military organisation which led to such appalling losses from preventable disease in the South African campaign—losses which, as Sir Frederick Treves suggests, should weigh heavily on the consciences of the British people.

Such diseases as dysentery and enteric fever should have been to a large extent prevented if the advice of the Army Medical Sanitary Officer had been taken.

There is another matter I wish to allude to, and which has led to much criticism and well-grounded discontent among the profession, which is—Why should the same Civil Members of the Medical Advisory Board be re-elected over and over again? Why should they not serve for a specified term and then not be eligible for re-election? Surely there are many other leading physicians and surgeons in the three countries quite as competent to take a seat on this board, and give the Department the benefit of their varied experience and advice.

The status and position of the army surgeon is now well defined, and it is a military service which any gentleman should be proud to serve in. I therefore have no hesitation in advising all those having a taste for military life to enter the R.A.M.C. It is at present undoubtedly a splendid service, and offers great advantages to the young doctor of culture and social position joining its ranks. The service also affords the medical officer an opportunity of seeing life and the world in some of its best aspects, and foreign service has many and varied attractions in our widely extended empire, and at the same time confers on the recipient a social status not easily attained so soon in civil life.

Only the other day one of my pupils, who is just qualified, met me in the hospital, and I asked him what he was going to do. He answered, "I intend, sir, to have a try for the Navy." My answer to him was, "Don't enter the service at present."

Three years ago in one of my Presidential addresses at the Royal College of Surgeons, I drew attention very strongly to the grievances of the Naval Medical Service as they then existed. I deeply regret the grievances and defects I enumerated at that time have not, as I sincerely hoped, been remedied, and in justice to our medical brethren in that service I must return to the subject again. They, of course, are precluded by the King's Regulations to mention or even hint at their well-grounded grievances while in the service. I shall touch on the points I spoke of on a former occasion.

1. *Promotion.*—This question since I last addressed myself to the subject has been satisfactorily settled, though as must be expected rank for rank the executive is considerable younger than the medical officer.

2. *Foreign Service.*—There is room still for considerable reform in this respect; at present there is no roster nor any method in the manner in which appointments are made, certain favoured officers going from one shore appointment to another, or, what is equally bad, remaining indefinitely in shore appointments. Many of these appointments are made, as a rule, not for conspicuous ability, but for conspicuous influence.

Treatment of this sort disheartens those who have, as a result of the system, an undue proportion of service afloat. It does not tend to efficiency, as instead of having, say, twelve men equally capable of doing certain work, at present only one has an opportunity afforded him of doing it. Too much service afloat to men who are keen on their work is most disheartening. The men who like the service afloat are generally those who take no great interest in their medical work. If it were known that service afloat and service ashore were fairly and equitably regulated there would be little or no discontent on this score. At present if a Naval Medical Officer gets through a commission afloat satisfactorily he often finds that instead of a hospital he gets another ship, or else he is told he can go on half-pay.

3. *Compulsory Half-Pay* is to be regretted, but it is difficult to see how it can be avoided if there are more officers than appointments, unless it be by putting unemployed officers through hospital courses or study leave.

4. *Control of the Sick Berth Staff.*—This is a very important matter, and should be remedied without delay. The control of the sick berth staff on shore should be entirely in the hands of the P.M.O., who should have precisely the same power when serving in a Naval Medical Establishment on shore as is enjoyed by his military confrères in the Royal Army Medical Corps.

The P.M. officers of the Royal Naval Hospitals at present have no power to deal with breaches of discipline on the part of the sick-berth staff that serves under them, whether ashore or afloat. An Inspector-General of Hospitals and Fleets ranking with a Rear-Admiral or Major-General in the Army, before he can get a man punished, has to report him to the Executive Officer at the local depôt, and much time is wasted in making out written reports in connection with the case, and in sending the offender and witnesses for a distance, which in the case of Haslar is over a mile from the hospital.

The P.M.O. of a naval hospital should have power to award minor punishments in hospitals and sick quarters. It is ridiculous and humiliating to the profession that a senior medical officer cannot legally stop leave, award extra duty, or stop pay for misconduct among the staff of a hospital or sick berth of which he is the head, more especially when we come to consider that the punishment has often to be awarded for misconduct and neglects which took place a considerable time previously, owing to delays, of which only a naval medical officer can appreciate the significance. It is no wonder, under existing circumstances, that so many irregularities occur in large naval hospitals. It is most humiliating that a naval medical officer of distinguished rank may at any moment have to buckle on his sword, leave his ward duties, and go to the depôt to give evidence against a careless, disobedient, or drunken sick-berth attendant, the punishment of whom could easily have been awarded by the Inspector-General if he had the legal power on the spot when the crime was committed. The Executive Branch of the Royal Navy is a closely guarded "trades union," exceeding jealous of its privileges and prerogatives, both official and social. The Executive Board dreads the loss of these privileges and prerogatives, and is loth to sanction any power being given to anyone outside it. However, public opinion must, and will sooner or later, throw a little wholesome light into these matters.

5. *Medical Guard.*—It is the recognised custom in the present day when two or more ships are in harbour together for them to take in turn to keep "medical guard," and the ship keeping medical guard flies a special flag for the purpose. The Medical Guard has to remain on board, and is always available in case a doctor is required in any emergency in any ship of the fleet. This excellent system has not as yet been embodied in the King's Regulations, and the result is that some narrow-minded captains who cannot resist the temptation of showing their authority still insist on always having one of the two medical officers belonging to the ship on board, although there may be nothing going on in the ship that the medical officer of the guard (close alongside and capable of being on board within five minutes of the signal being made) could not attend to. The result of this is that the Fleet-Surgeon or Staff-Surgeon of a big battleship of this nature may find himself worse off than a Junior-Surgeon of a gunboat. Another captain will insist on both the Fleet-Surgeon and Surgeon being on board when his ship is medical guard. In other words, the Fleet-Surgeon, ranking with a Lieutenant-Colonel in R.A.M.C., is made to do the work of a surgeon ranking as a captain in the Army.

All this red tape is extremely galling to the medical branch of the Navy, more especially as no means of

redress can be obtained, for if the Fleet-Surgeon protests he is referred by the Captain to the Article in the King's Regulations saying that he must obey all orders he may receive from his Commanding Officer.

It should be clearly laid down in the King's Regulations that Medical Guard is to be recognised by the Captains and Commanding Officers of all ships, thus putting it beyond the capricious exercise of executive authority.

6. *Medical Surveys.*—To be an Inspector-General is the ambition of most Naval doctors, and it is disheartening and humiliating in the extreme to see these officers, ranking as they do with Major-Generals, forced to sit at Medical Surveys which are held for purely medical purposes under the presidency of a Captain or Commander of the Executive Branch. This is not only an absurdity and an indignity to the whole medical profession, but it is a direct cause of inefficiency, for the Executive Officer can of his own mere motion overrule the decision of all his medical colleagues on matters as to which he is incompetent to form a judgment. Such a condition of mistrust is lamentable, and is injurious not only to the Naval Medical Service but to the whole profession, for these Executive Officers, on retirement as Admirals, etc., carry with them into civil life the same wretched opinion of the status of the medical man as they have seen in the Navy. The matter is becoming one of national importance, and calls urgently for reform, and we, civil practitioners and hospital teachers, with all the weight of our influence, are bound to speak, write, and agitate in a forcible way, by argument and common sense, to remove the grievances and hardships which our naval brethren suffer from. For, as I have already said, by the King's Regulations, the naval medical officer is precluded from publicly ever making known his troubles and injustices.

In the Army the medical officers not only preside over their own Medical Boards, but sit as president, if senior, over all junior combatant officers, on all classes of boards.

7. *Courts Martial.*—When a medical officer is tried by court-martial for any offence, professional or otherwise, his judges are entirely seamen. It is the general desire, and it is only right, that some of the members constituting the court on such occasions should be medical officers of high rank.

8. *Salutes.*—It is very painful to see the neglect shown to naval medical officers as to salutes. Junior officials constantly pass them by without saluting them. This breaks down self-respect and the respect of the men. A Fleet-Surgeon is not entitled to "laying on oars" or to "letting fly sheet," as is the commander who may be years his junior. In the Army a medical officer of General's rank is entitled to the "turning out of the guard" like any other General, but an Inspector-General of Hospitals and Fleets going on board a warship is not so saluted. Why? Because, as the executive officers say, "he is only a doctor."

9. *Boats.*—In the matter of boats in harbour a senior medical officer has much to put up with. The Captain and Commander each have their own six-oared boats, which are at their own disposal at any and all times, yet senior officers like Engineer Commanders, Fleet-Surgeons, Fleet-Paymasters, or Naval Instructors of over fifteen years' seniority, all of whom rank with Commanders, must put up with the same boats at the same times as the youngest midshipman or most junior warrant officer.

In some ships the practice has of late obtained of putting one boat at the disposal of all officers of Commander's rank to take them ashore and bring them on board at such times as are mutually convenient. This practice should easily be carried out in all ships if it were generally recognised. At times it would be inconvenient, but the good sense and good taste possessed by the majority of senior medical officers would tell them when to waive their claims, thereby enhancing rather than lowering their dignity.

10. *Honours to Naval Medical Officers.*—The way in which the naval medical officers have been persistently ignored in the "Honours List" is proverbial. Fancy the Director-General and head of a department of over five hundred naval medical officers, a man who is responsible for the organisation of a body of surgeons for the whole British Navy, to be still allowed to remain without any recognition whatever, civil or military. In fact, there is not a single K.C.B. in the whole department on the active list, and only one C.B. and one M.V.O. I am aware on the retired list, among the Honorary Physicians and Surgeons to the King, there are a few titles given to these officers, but they are very few when compared with the officers of the R.A.M.C.

11. *Cabins.*—This matter, which affects the comfort of senior medical officers so much, has ostensibly been settled by the Admiralty, *vide* King's Regulations, 1906, Articles 836-837, pp. 298 and 299. In the former (paragraph 2) it says—"Special cabins are appropriated for the Executive Officer (this means the second in command), the Navigating Officer, the Chaplain, the Medical Officer, the Accountant Officer, and the Engineer Officer, the particular duties of the officer guiding the selection, and in ships fitted as flagships for the Secretary and the Flag-Lieutenant. A cabin will also be appropriated to the Second Engineer Officer, the position being fixed as near the engine-room as is convenient and practicable. The appropriation of these cabins is not to be altered without Admiralty sanction."

Paragraph 4, same article, states—"Officers will be allowed a cabin in the following order of priority:—

(*a*) Watch-keeping lieutenants in the complement.

(*b*) Engineer Lieutenants in the complement who keep watch at sea.

(*c*) Other wardroom officers not keeping watch in the order of their relative seniority.

"The Subaltern of Marines is always to have a cabin.

"Officers who have been allowed numbered cabins should be permitted to choose their particular cabins in the order of their relative seniority."

Now, one would have supposed that the Article (837, par 2) would have settled the question in a satisfactory manner. But hear what nearly always happens. When a ship is being prepared for commissioning she has a Navigating Officer and one or more Engineers appointed to her. These officers have an opportunity, therefore, of selecting their own cabins first, so that on commissioning it is found that "tallies," Navigating Officer, Engineer Commanding, Engineer Lieutenant, are over their respective doors, and these cabins are secured to them irrespective of the fact that the medical officer may be years senior to them, and these officers have to put up with whatever indifferent cabins it has pleased some minor dockyard official to place their "tallies" over.

In many instances the sewer pipe from the upper deck passes through the Fleet-Surgeon's cabin, and in other instances coal shutes and other abominations pass through it. If corroboration of these facts be desired an inspection of the nine ships of the Majestic class and the eight ships of the Royal Sovereign class will prove their truth.

I have heard in a ship in one of the fleets fitted as a flagship, but not carrying an Admiral (I believe there are several), the captain has ignored Article 837, par. 2, and insisted on the Fleet Surgeon occupying cabin labelled "Fleet-Surgeon," situated next the ward-room pantry, where he is not only annoyed by the constant chatter and noise made by the ward-room servants, but also in warm weather subjected to the annoyance of an invasion of cockroaches, which swarm wherever food is prepared.

Those captains who insist on their officers occupying these cabins appropriated for them invariably occupy those allotted to the Admiral, and turn their own cabins over to the second in command. The majority of ships nowadays are fitted as flagships, so that, except when the flag of an Admiral is actually flown on a ship, the question of selection of cabins invariably crops up, and unless the naval medical officer is a man with some force of character, grit, and determination, he is sure to go to the wall. As the executive

would imply by their action—anything is good enough for the "doctor."

12. *Social and Professional Respect.*—The Editor of the *British Medical Journal*, in a leading article, said—*inter alia*—"The refusal by certain commanding officers of the social recognition which is due to men who are at once officers and members of a learned profession is a subtler but not less galling grievance. This is a thing that can scarcely be dealt with by an Order in Council or Admiralty Instruction, for no authority can transform a naval officer who is a snob into a gentleman. Social recognition is largely a personal matter, and a naval medical officer who knows his work, and who, in his behaviour, shows a proper sense of the dignity of his profession, may, as a rule, hope to have little trouble on that score. The social difficulty, such as it is, would disappear of itself if medical officers were given the measure of authority in their own sphere which has been shown to be absolutely essential."

Lord Wolseley, in his "Soldiers' Pocket Book," sarcastically remarks that—"Medical advice is very valuable when it is asked for." Had he served in the Royal Navy he would have added—"and when it agrees with the opinion you have yourself already formed." Quite recently, and this is not exceptional, a man was reported to the officer of the watch on board a certain ship as being drunk. The officer of the watch examined the man, and pronounced him to be drunk. The man thereupon requested that he might be examined by the naval medical officer. The latter gave as his opinion that the man was sober, and capable of performing his duty, yet this man was kept under arrest, and when brought up for trial the medical officer's opinion was set on one side and the evidence of a sergeant of marines taken as of more value. When the medical officer afterwards protested against this treatment he was told that "we (Executive Officers) are the best judges of a man's fitness for duty. All we want to know is whether or not a man is ill." It would appear that a medical officer's opinion is only of value when it supports the opinion already formed by the prosecutor.

There are many other petty annoyances which irritate the naval medical officer, and to which time will not permit me to allude; but a little re-arrangement could easily remedy these matters without any loss of discipline or efficiency.

The present Director-General (Inspector-General Ellis) has done much to improve the service, and I know he has the interests of the service at heart, and is only too anxious to see his branch brought into efficiency and popularity. But I have no doubt that when he suggests improvements he is stopped by the Treasury, which will not sanction any improvement that costs additional money. The Government yearly expends millions on the building of warships intended to inflict death and suffering on our fellow-men if our interests should so demand. How much more, in the cause of humanity, should they be willing to spend a few thousands on a branch of the service whose mission it is to prevent or cure disease, and alleviate the suffering inflicted by shot and shell on our fighting men.

If the present Director-General fails to induce the Admiralty and the Treasury to amend these grievances by mild expostulation, these authorities will be forced in the long run to yield, because men will not go where discontent and limitation of status are maintained. In the end the Admiralty will have to follow the example of the Army, and at once accede to the suggestions of an energetic and independent civilian Advisory Board, constituted on the same lines as the R.A.M.C., but called in the Navy the Medical Consultative Board.

The R.A.M.C. now gets plenty of well-qualified candidates, but in the Naval Medical Service there is a deficiency of over fifty surgeons.

If many of these grievances are not removed shortly the remedy is simple and in your own hands. Avoid the Naval Medical Service for the present, which will compel the authorities, in order to get good men, to rectify the glaring defects by placing the naval medical officer in his proper position, and giving him, in all fairness, equal advantages socially and professionally with his less scientifically educated executive brother officer.

THE OUT-PATIENTS' ROOM.

FRENCH HOSPITAL AND DISPENSARY.

By J. P. BARONOFF, B.Sc., L.S.A.

GUMMA OF THE PENIS.—A man, æt. 48, who had syphilis fifteen years ago. He came with an ulcer on the penis, which at first was taken for a primary chancre. The glands in the groin were enlarged. The patient had had no connection lately; his wife died a short while ago. The man is a hairdresser. Mercury was given. A month afterwards a pustulous eruption came on the dorsum of both hands and also on the face. After a fortnight's treatment the patient was very much better. Mr. Baronoff said that the lesion on the penis was in his opinion a broken-down ulcerated gumma. This being a very rare lesion, he thought at first that the patient had been telling an untruth about having had no connection, though even had the man had connection he could only have considered the lesion a modified chancroid. The eruption on the hands was undoubtedly tertiary.

MITRAL INSUFFICIENCY.—A young woman, æt about 28, very thin and anæmic-looking, complained of weakness and a constant feeling of coldness; also of palpitation and dyspnœa. She came first about three months before, suffering from mitral insufficiency, with intermittence of the pulse. She had rheumatic fever two years ago, and during the course of the fever she suffered from endocarditis. Digitalis was administered with carbonate of ammonia. She improved greatly under this treatment. After three weeks the medicine was only continued irregularly. Since then she had taken a tonic. Mr. Baronoff laid stress on the importance of watching a patient carefully during a treatment by digitalis, which must not be continued for too long.

TERTIARY SYPHILIS.—A man, æt. about 59, presented himself with an ulceration at the angle of the mouth on the left side, which had been present for twelve months. He came up from the environs of London, and had been treated locally for some time, but without benefit. The ulceration was about the size of a bean, and was of a slate colour. After a little hesitation the patient acknowledged to have had syphilis fifteen, twenty-five, or thirty years ago. Mercury was ordered internally, and a little blue ointment for local application. In three weeks the ulceration had completely healed. Mr. Baronoff commented on the insidious appearance of these tertiary lesions, which he considered as very difficult to diagnose, especially in the present case, as there were no other symptoms whatever—no eruption, no glandular enlargement in the neck. The patient's history of syphilis was, however, very clear, but he had had four or five healthy children. The syphilis had been contracted before marriage. The sore was, Mr. Baronoff considered, an ordinary tertiary ulceration, not a gumma. The healing of the ulceration under the treatment confirmed the diagnosis.

OPERATING THEATRES.

ST. THOMAS'S HOSPITAL.

MULTIPLE NECROSES.—Mr. H. BETHAM ROBINSON operated on a girl, æt. 17, who had the following history:—In September, 1904, she had been admitted into the hospital with an abscess on the outer side of the right os calcis which had come suddenly only one week before; this was opened and only pus came out. Two weeks before the abscess appeared there had been a whitlow on the right thumb. She was

in the hospital two months, and when she left the abscess on the os calcis was healed. Three months after leaving the hospital there was some swelling on the upper part of the left arm; two months later there appeared in this region a "boil" and a piece of bone came away. The sinus so left had continued discharging up to the time of the present admission, but no more bone had come away. In August, 1906, a little red spot was noticed over the left side of the sternum, about the junction of the manubrium and the gladiolus; this spot had broken down, presenting an ulcer about the size of a half-crown, with overhanging skin edges at its outer margin. She was readmitted to the Hospital in September, and the following operation performed on the 14th: The sinus over the upper part of the humerus, which was near the anterior border of the deltoid and close to its anterior edge, was explored by making a vertical incision, splitting the muscle fibres and exposing the humerus. The humerus was locally thickened, and a director passed through the hole in the bone gave evidence of a definite sequestrum. The thickened bone over this was cut away with a gouge and a cavity exposed lined with granulations in which rested a well-marked spiculated sequestrum about two inches long. The place over the sternum was next explored; a bullet-probe passed under the undermined skin tracked outwards across the chest under the pectoralis major; this track was slit up by cutting the skin and splitting the muscular fibres in their length, but nothing more definite was found than a cavity at the right axillary margin filled with broken-down granulations between the second and third ribs. The wounds necessitated by this operation made good progress. Later another abscess was noticed on the right side of the spine filling the interval between the spine and the vertical border of the scapula. On opening this on October 2nd a large quantity of pus was set free, and its origin was traced to a round hole in the seventh rib just outside the margin of the erector spinæ. The hole in the rib, which had well-marked rounded edges, was about the size of a large pea, and the rib itself was broadened at this spot. A probe passed through the hole entered a cavity, to reach which the portion of the rib forming the lower part of the hole was removed. The cavity was filled with granulation tissue, and no further necrosed bone was found; in the pus from this abscess cavity a very small sequestrum was detected, and it was evident that it had come from the hole in the rib. Mr. Robinson said that the interest in the case lay in the diagnosis; it was a question as to whether the condition was due to syphilis, tubercle, or to some acute infective process. With regard to syphilis, there was no evidence of any hereditary taint, and the history of the development of the illness pointed strongly against it. With regard to tubercle, first appearances of the lesions present suggested such might be the cause, but the presence, on exploring the wound in the humerus, of a well-marked sequestrum was a point against it, as necrosis of the shaft of the long bones in tubercle was unusual; this opinion, Mr. Robinson considered, was supported by the history. The important point in the history was the development of the whitlow before the subsequent bone lesions; there seemed little doubt that the girl had had a mutiple staphylococcic infection secondary to the whitlow, which accounted for the foci of the disease of the bones with subsequent necrosis. A point brought out, he remarked, as occurs in many of these cases, was that one lesion particularly is often uppermost, as in this case the abscess of the os calcis, whereas other lesions keep considerably in the background, their existence only being brought to light afterwards by the slow appearance of an abscess, which, on opening up later, is found to be related to the necrosed bone. It was the slow development of these abscesses when the primary condition has not been sufficiently recognised that, he thought, caused many of these cases to be put down as tuberculous, and he would impress the fact that in multiple bone lesions somewhat chronic in nature in a young subject one has to consider the much greater probability of their being due to some acute infecton, such as the staphylococcus, rather than to tubercle.

The child is still in the hospital, and is making good progress.

TRANSACTIONS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON.

MEETING HELD OCTOBER 12TH, 1906.

The President, Mr. CLUTTON, in the Chair.

AFTER a few words of welcome, the President began his address on the subject of

ADOLESCENT OR LATE RICKETS.

His first case was that of a man, æt. 21, when he came under observation nearly three years ago. His history showed that at the age of 12 he had had to wear supports for Genu Valgum, that osteotomy was done for both knees at the age of 16, and that the present curvature of lower limbs began to appear at the age of 19. The most striking part of his deformity was a double curvature at the knees producing a general resemblance to Genu Recurvature. Patient shown. The skiagram-photographs which were thrown upon the screen proved that the changes in the bones were of very long duration and had apparently commenced at the epiphysial lines. In the shafts of the long bones adjoining the epiphyses there was much less cortex than normal, and a large and translucent medulla. It was at this part that the curvature, which was the cause of the deformity, had taken place. The diagnosis of rickets was established by the changes that were seen at the wrists. The lower epiphyses of the radius and ulna were shown by means of X-rays to be in the active stage of rickets. Almost all the long bones showed changes at the ends of the diaphyses adjoining the epiphyses. Two other cases were shown and illustrated by means of skiagrams. They were æt. 12 and 14. The disease had arisen quite recently and was limited to the epiphyses. The contrast between the younger patients and the older one whose disease had been in existence for many years was the most interesting feature of the demonstration. Two *post-mortem* specimens were also shown, one from the Royal College of Surgeons, and one from the Hospital for Sick Children. A large number of skiagrams taken by Dr. Greg at St. Thomas's Hospital were also shown.

Mr. MUIRHEAD LITTLE described a similar case occurring in a girl, æt. 17. Infantilism was well marked. The changes in the bones were extremely typical of rickets.

Mr. CLEMENT LUCAS, after congratulating the society on the excellent address, said that the President had revived a discussion he had instituted in 1883. He referred to a paper then published in the *Lancet*, in which he had tried to establish a connection between late rickets and Moxon's intermittent albuminuria. He thought that the emotional state of puberty, with its uncontrolled passion, favoured the occurrence both of albuminuria and rickets.

Dr. PARKES WEBER suggested that cases of late rickets be investigated from the point of view of

albuminuria. It was interesting to recall that calcium salts cured most cases of cyclic albuminuria, as Wright has shown, whilst it has little or no influence on rickets.

The PRESIDENT, in reply to a question of Mr. Godlee's, said that he knew of no case that had occurred in a well-developed individual.

Mr. R. C. ELMSLIE, who showed two cases of the condition, said that though the occurrence of rickets in adolescence was established beyond doubt, its origin then was very doubtful. To prove that the child had never had rickets before was difficult for the following reasons. The history was very untrustworthy. In a large number of consecutive cases he had found distinct rickets in over 50 per cent. of the cases, whilst in only 1 per cent. of these was the existence of the condition known to the mother. The physical signs of rickets in these cases had nearly always disappeared by the age of 8, except for the puny development and head changes, particularly a curious high forehead. Now, these two features were invariably present in cases of adolescent rickets, suggesting thus an early origin.

Similar cases were also shown by Drs. G. A. Sutherland, J. A. Coutts, and R. Hutchison.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

INAUGURAL MEETING FOR THE SESSION, FRIDAY, OCTOBER 5TH, 1906.

THE President, DR. LEONARD MARK, delivered an address on

ART AND MEDICINE.

After thanking the Society for the honour which they had conferred upon him by electing him their President, he said that medicine had found a place in art since the earliest dawn of civilisation, and medical details have had to be represented in painting and sculpture just as well as details connected with other sciences or with sport, navigation, and the art of war.

If one studies the old masters, one sees that in some of their work great care is taken to hide details of a morbid nature or to touch them very lightly. Some examples of pictures from British galleries and art museums were shown by lantern slides to illustrate the subject. One of the most important was Raphael's famous cartoon at the South Kensington Museum, representing St. Peter curing the lame man at the gate of the Temple. Here it was shown how the artist had grouped his subjects so that a shadow from a column was cast over the deformed legs of the cripple.

Some facts concerning St. Roch and St. Sebastian in connection with the plague in the Middle Ages, and their important place in art were dwelt upon. Van Dyck's fine picture at Windsor Castle of St. Martin cutting off a portion of his cloak to give to a leper was described, with an account of the leper's appearance.

The subject of history came in, and the morbid peculiarities of some of our sovereigns which have been recorded in art were dwelt upon—Edward the Confessor, who was an Albino; Richard III., the hunchback; Edward VI., the boy king who died of consumption; and Mary I., whose appearance in some of her pictures is that occasionally seen in sufferers from ovarian disease.

In the part dealing with sculpture and carving, a curious ivory statuette of a dwarf with Pott's disease, to be seen at the British Museum, was mentioned.

A photograph was shown on the screen of the doctor's signboard of the seventeenth century, now at the Royal College of Surgeons, with some quaint groups of carved figures representing the doctor at his daily work.

The subject of death as represented in painting had an important place in the paper.

Reference was also made to a few modern pictures, such as "The Death of Chatterton," by Henry Wallis, Millais' "Ophelia," floating in the water, and, last of all Luke Fildes' "The Doctor." In this picture morbid details are conspicuous by their absence, and the whole interest of the picture is expressed in the distress in the face of the father, and the mother's attitude of despair, and the kindly look of the doctor, which is full of concern.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Oct. 15th, 1906.

COXALGIA.

THE commencement of coxalgia is insidious. There is a certain amount of claudication, and pathological anatomy teaches us that at this moment there is an increase in volume and a certain vascularity of the fringes of the synovia, with an increase in the serosity. Still more, and what is unfortunately more serious, says Professor Kimisson, there exist lesions of the cotyloid cavity and of the head of the femur.

In two-thirds of the cases the tubercles end in suppuration.

The malady terminates in one of three ways—suppuration, ankylosis, and preservation of the movements.

Suppuration is revealed by an increase in the pain and high evening temperature. Hence the necessity of changing frequently the apparatus, for the issue of the pus is effected either by the classical manner, femoral abscess, gluteal abscess, or pelvic abscess, or else in more unusual positions: iliac fossa, Scarpa's triangle, great trochanter. Reabsorption may take place, but it is rare. Once the abscess opened, septicæmic fever sets in, endangering the outlook.

M. Kimisson fixes at three years the period necessary to obtain a cure, as in Pott's disease.

The treatment consists in immobilising the limb in a plaster apparatus. If at the end of a year and a half there is no pain provoked by movements or pressure, if there is no fever nor abscess, the case might be considered as cured, and attempts at walking might be allowed.

If an abscess is formed it should not be opened with the bistoury, but the pus drawn off with an aspirator and a solution of ether and iodoform injected. Where the abscesses are formed at an early date the prognosis is grave, but those appearing after two or four years heal very easily.

Forced extension should not be used, but continued extension by means of a weight of 8 or 10 lbs. for a child of 8 or 10 years. Surgical operations have not given good results.

Dr. Privat, of Berck-sur-Mer, considers it of the highest importance that the practitioner should detect coxalgia in its incipient stage, for which purpose he enumerates certain signs and symptoms that should attract the attention of the medical attendant.

Each time that a child is brought to the consulting-room presenting one of the three following symptoms: (1) the child suddenly awakes at night complaining of pain either in the hip or in the knee; (2) the child gets tired very quickly—after a walk or long standing he complains of pain either in the hip or the knee, which, however, disappears after a rest; (3) the child, hardened to pain, does not complain, but the parents have remarked that he limps a little. Such are the first symptoms of the malady, and are of value, but the diagnosis must be based on three other characteristic symptoms which are the natural sequence of the preceding: (a) limitation of movements of abduction of the hip; (b) pain on pressure on the head of the femur; (c) lengthening of the limb. To discover the first symptom, the healthy limb should be examined carefully in all its movements, the leg flexed on the thigh, the thigh on the pelvis, and while the left hand presses on the anterior and superior iliac spine, th

right hand seizes the knee and abducts the thigh, so as to make it touch the surface of the table, and the experiment succeeds without any trouble. Not so in the diseased side. The movement is arrested, the adductor muscles become like cords on the inside of the thigh, while if the knee goes down under the pressure of the hand, the iliac joint goes up. To find out if the parts are painful it is not necessary to hit the heel of the patient, as is generally practised; it is far better to make direct pressure over the head of the femur.

To arrive at this result, the practitioner will act as in the case of appendicitis, where the finger is pressed down over the MacBurney point.

The point which corresponds anatomically to the head of the femur is situated perpendicularly to Poupart's ligament, about its middle. It suffices to draw an imaginary line between the iliac spine and that of the pubis, and take the middle of that line. This point is situated at a quarter of an inch external to the femoral artery; or, more simply, the head of the femur is to be found in the angle formed by the femoral artery and the crural arch within half an inch of the apex of this angle and close to the interior border constituted by the artery. The experiment should be first made on the healthy side. The index is pressed gently on the fixed point, and the same operation done on the other side. If no pain is produced, the operation should be repeated, and for several times if needs be, but each time the pressure should be increased. With a little perseverance the pain will be provoked on the suspected side. If the two signs, limitation of abduction and sensibility of the head of the femur, are present, the case may be considered as being arthritis of the hip; if the third, or lengthening of the diseased limb, be also discovered, the diagnosis should be that of coxo-femoral tuberculosis.

If, concludes Dr. Privat, pain is absent a doubt might be entertained, but in any case the child should be undressed and the vertebral column, as well as the knee and the foot, carefully examined for possible Pott's disease, a white swelling, or some general affection.

GERMANY.

Berlin, Oct. 14th, 1906.

The External Application of Alcohol in Inflammations.

This subject has been many times brought before the profession, but the systematic use of alcohol in inflammations has never seemed to catch on. A recent paper on the subject in the *Therap. Monatsch.* for September, by Dr. Alexander Raphael, of Mitau, brings it once more forward.

Alcohol compresses of wadding in lint were applied and covered with an impermeable waterproof layer and kept undisturbed as long as they were moist. To remoisten them the upper waterproof layer was simply lifted up and the spirit poured again on to the compress. A strength of 90 to 95 per cent. of alcohol was made use of. Eight cases of appendicitis were treated in this way; one case terminated fatally on the fifth day, the others recovered. The compresses were kept on from two to six weeks. They were only removed when the skin became sore and blisters formed. After powdering with salicylate of bismuth and a day's rest, the dressing was recommenced and again well borne. In one case of tuberculosis of the mesenteric and pelvic glands in a lady, æt. 40, the treatment was kept up practically for three months. One gland after another suppurated and burst into the bowels, as in the appendicitis cases. In all the cases the first thing noticed was that the pain ceased in a short time. The symptoms of toxine poisoning in the blood, headache, and sleeplessness got better. The objective results were improvement of the pulse and fall of temperature. The inflammatory exudation became firmer, it seemed more distinct from its surroundings; melting down of the centre followed without much pain. The fever subsided usually before the bursting of the abscess, whilst the pulse only slowed after this had taken place. Two of the appendicitis cases did well without any pus appearing in the stools.

In a case of suppurative parametritis after abortion in a patient æt. 28, the exudation became localised. At the operation of opening—incision parallel to Poupart's ligament and drainage through the vagina—the walls of the abscess cavity were seen well covered with firm granulations.

A case of mastitis that had been opened but would not heal up was brought to the writer, who treated it with tampons soaked in alcohol, when it healed up quickly. Cases of early mastitis frequently ended by resolution. Cases of tendovaginitis phlegmon, as well, generally ran a favourable course under spirit compresses. The compress was also used when the abscess was ripe for the knife. The wound was filled with iodoform gauze tampon, and alcohol then poured on so long as necrotic slough continued to show. In this way two things were achieved: first, the flabby granulations disappeared, the sloughs were also cast off more quickly, and were in many cases mummified by extraction of water

Some cases of scrofulous glandular swelling the size of a hen's egg in the neck and under the chin became visibly smaller under compression. The pain caused by the spirit on an open wound disappeared in the course of a few minutes. For some time he had treated all sorts of smaller wounds, bruises, and cuts by washing the surrounding parts with alcohol, suturing if necessary, then placing over the wound a compress of iodoform gauze soaked in alcohol, and fixed on. He has been much pleased with the results. Union generally took place by first intention, and he has never seen gangrene of the skin for a long time. A good effect was produced also in skin diseases, especially in children. Before any ointment was applied to the skin it was vigorously rubbed with a pledget of lint soaked in alcohol. The ointment acted much more energetically and penetrated into the pores better. In eczema a 10 per cent. solution of epicarine acted much better than a lanoline ointment of like strength. Herpes zoster and erysipelas ran a favourable course. A case of vascular nævus at the root of the nose healed up under the alcohol compress, leaving a firm white cicatrix at the spot. Some cases of commencing inflammation from injury recovered in the course of twelve days under alcoholic compresses.

Dr. Raphael has also syringed out the uterus with a 45 to 50 per cent. solution of alcohol in retention of membrane and pieces of placenta, and also in case of puerperal fever. He first syringed out both vagina and uterus with camomile tea and then allowed 200 to 300 grm. of a 40 to 60 per cent. solution of alcohol to run slowly through. If this strength was well borne, as it almost always was, he proceeded to more concentrated solutions up to 90 per cent. Whilst this was being done the external part had to be protected by vaseline. Both in the uterus and vagina the alcohol was only felt as an agreeable warmth. Finally a tampon of alcohol was placed in the vagina. All cases of this kind also had alcohol compresses over the abdomen. In all cases of retention of membrane the fever sank rapidly, and the shreds were soon expelled. The only case of puerperal fever ended in recovery after some weeks of illness. Whether recovery was due to the alcoholic treatment would be difficult to say. Two cases of perforative peritonitis in connection with typhoid and treated with alcohol compresses are also described. Both terminated favourably, and in both the favourable termination was attributed to the alcoholic dressings.

AUSTRIA.

Vienna, Oct. 14th, 1906.

Cysticercosis Cerebri.

Chiari related the history of a man, æt. 45, at the Prague meeting, who six years ago commenced having epileptiform attacks, which gradually produced

a form of dementia ending in death after an apoplectiform attack. The cysticerci were found distributed through the brain substance in different stages of growth. The vesicles were found in groups extending along the spinal cord, where two were found as far down as the cauda equina. Although cysticerci cellulosæ is common enough in Prague as an accident from impregnated food, he has only seen other two cases that led to death.

PROPHYLAXIS OF TUBERCULOSIS.

Hueppe next read an exhaustive paper on tuberculosis and how to prevent attack. He said it has often been repeated that it was a difficult problem to solve, as we could not definitely fix the path by which the virus was introduced. According to the oldest record we have—the Bible—the mode of infection is by contagion. Pettenkofer held the opinion that locality was the most potent factor. Cornets avowed that dust inhalation was the cause; Flügge maintained that the poison was conveyed by moisture; while Koch frightens us with the communion of animals; and lastly, Behring and Weleminsky tell us that the nature of our food is responsible for the whole destruction of life. In the prophylaxis of the disease four factors may be considered—viz., exposition, infection, disposition and invasion. With our obscure knowledge, exposure to risk should always be avoided. This prescription must be very limited, as we cannot under the present circumstances ostracise a fourth, at least, of the human race as unfit for society.

According to statistics, the nature of employment and surroundings have something to do with the mortality, and nurses are not without this danger. Those engaged in general work have a death-rate of 30 per cent., the Red Cross have 33 per cent., Diaconal have 52 per cent., while the Roman Catholic sisters have 66 per cent. It would seem, therefore, that one-half of the nurses and a third of the population, which have 24 per cent., are afflicted with this fatal disease. There is no doubt that the ascetic life of the Roman Catholic sisters has much to do with the attack, being drawn together in close rooms with poor food, where everything would favour transmission. It is to be noticed that different orders in this religion have higher death-rates, some of them even reaching 92 per cent. Care should therefore he exercised on the nursing personnel. Change and open air are always to be recommended to such patients, as sanatoria always give the best results; even here the more susceptible require to be educated in personal hygiene to make the prophylaxis more complete. Jaksch pleaded for more stringent regulations to prevent spitting in streets and public places, as the bacilli got mixed with the dust, which again was inhaled by the healthy. There was no doubt that infection could be conveyed by clothing in close rooms where the bacilli were transmitted to the healthy. Although Koch tells us that human and animal are different, it is certain that animal infection does much destruction. Taussig remarked that workshops seemed to have a heavy record in this respect, as the deaths occurred between sixteen and sixty.

MORBUS BASEDOWII.

Jaksch next presented a patient suffering from enlargement of the thyroid, for which he had tied the thyroid artery inferior, with the result that the entire bony structure became affected. As time advanced the long bone began to split and atrophy. The radius and ulna have recently broken symmetrically in both hands, and the arms are totally atrophied. The scapula is as thin as paper, the clavicle like a quill, and the diaphyses of the humeri separated. The patient is also suffering from an atrophied osteomalacia of the pelvis, while the bones of the lower limbs are similarly wasted. The whole was clearly demonstrated by the Rontgen rays. He considers Basedowii a disease closely allied with the nutrition of the bony structure, as Hornicke long ago pointed out.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

EDINBURGH.

VICTORIA HOSPITAL FOR CONSUMPTION, EDINBURGH.—This hospital is to be enlarged by the addition of an administrative block and two pavilions containing twelve beds each. The latter are exact copies of the pavilions which were erected some years ago, and which have been found in every respect admirably adapted for the purpose for which they were designed. The principal feature of the new building is the patients' dining hall. Up to the present the offices of the hospital have been housed in the old mansion house, the pavilions being distributed through the grounds, and with the growth of the latter more extensive administrative and central buildings have been greatly needed.

EDINBURGH POST-GRADUATE CLASSES.—The post-graduate course which has just terminated has proved a success far surpassing the expectations of its promoters. Both in point of the numbers of graduates attending it, and on the enthusiasm with which the various teachers entered into the scheme, it has been carried through in a most satisfactory manner. The graduates who took part in it have almost unanimously expressed themselves as delighted with the way in which the classes were conducted, and there is now little doubt that this resuscitated course will be carried on steadily from year to year. The energetic secretary, Dr. Edwin Bramwell, deserves to be congratulated on the success which has attended his labour of love.

COTTAGE HOSPITALS AT MOFFAT AND CRIEFF.—During the past week cottage hospitals for non-infectious diseases have been opened at Moffat and Crieff. The Moffat Hospital, which was opened by Mr. William Younger, of Anchor Castle, is a one-storey building consisting of two large and one small private ward, with a surgery suitable for performing operations in. The hospital has been erected by means of a fund which came into existence in 1890, as a result of litigation between the working men of the town and the Working Men's Institute. The Crieff Hospital is much on the same plan. It was opened by Mrs. Whitelaw, of Strowan, who has taken an active part in promoting its erection. In both cases the architect was Mr. Maidman, Edinburgh.

EDINBURGH UNIVERSITY UNION.—The enlarged Union buildings are now completed, and will be opened on the 19th by the Lord Rector, the Right Hon. R. B. Haldane. Mr. A. J. Balfour, the Chancellor of the University, will preside. After the opening ceremony there is to be a reception, followed in the evening by a house dinner. The University Union was opened about seventeen years ago, and some idea of its popularity and success may be gathered from the fact that whereas the original buildings, which seemed spacious enough to the first members, cost some £16,000, the required accommodation provided by the recent extensions has cost nearly double that sum. The membership of the Union has greatly increased since 1897, when the Union Committee took the catering into their own hands, and now amounts to 1,200. The work of raising funds for the extension was begun at a meeting held in the MacEwan Hall in January, 1903, whereafter a site immediately to the west of the present building was secured. Owing to lack of funds the additions were proceeded with piecemeal, the first extension comprising a side room to the large hall, with additional lavatory and storage accommodation. Next the dining hall was enlarged, a new billiard-room taken in hand, and electric light installed. The third and most important addition is now finished, and includes library and reading-room, committee and writing rooms, and two fives courts. The new wing contains a spacious library with a gallery and eight bays, capable of containing 8,000 volumes. Adjacent to this is a general committee and writing room; while in the same section of the building there is a barber's saloon with bath-rooms and lavatories. The old library and committee rooms have been thrown into the entrance hall, which

was formerly somewhat cramped. On the upper stories of the new wing there is a large luncheon room, a new kitchen, and a large reading and writing room, which can also be used for functions for which the large hall is unsuitable. Up to the end of July the Union had raised about £8,000 of the £26,000 needed. Since then Sir Donald Currie and Mr. Andrew Carnegie have each promised £6,000 on condition that the balance of £6,000 be raised within a year.

GLASGOW.

The Late Dr. Finlayson.—A Personal Reminiscence.—Dr. James Finlayson, physician to the Western Infirmary, Glasgow, died suddenly at his residence on the 10th inst. He was in his sixty-sixth year, and appeared to be in his usual health, when he was struck down by cerebral hæmorrhage. Dr. Finlayson was born in Glasgow on the 22nd day of November, 1840. He graduated M.B. in 1867 with honours. Dr. Finlayson received the honorary degree of LL.D. of Glasgow University in 1899, for his eminence as a physician and his many valuable contributions to medical literature. He received his early training under Sir W. T. Gairdner, who might be said to have founded in Glasgow a school of philosophical physicians, of which Finlayson was a bright example. They were versed not only in the history of diseases, but nearly as much in the history of mankind. Although Lister had by this time pointed the way, in a practical fashion, of ascertaining the causes of diseases in the invisible fauna and flora surrounding the bodies of animals, little work was done by the Glasgow Philosophical School in following up Lister's brilliant ideas, which have been so fruitfully pursued in laboratories in London and the Continent. After the patient died we followed him to the post-mortem room, and there we saw the gross anatomical lesions which were supposed to be the cause of the disease the patient suffered from. At least, that was the idea given to students some twenty years ago. It must be said, however, that pathological anatomy was pursued with great avidity, and Drs. Joseph Coats and Lindsay Stevens' work can scarcely be forgotten. The painstaking way in which a case was overhauled, the elaborate life-histories elicited, the post-mortem records connecting the past life history of the individual with the anatomical changes in the organs, all this was calculated to make first-class clinicians, but not original investigators. I think it may be said with truth that there can be few schools of medicine with finer clinicians than the Glasgow school, and Dr. James Finlayson was one of its brightest ornaments. His "Clinical Manual" was the guide of many generations of students, as year after year fresh men came to the wards. But this work got superseded in later years, as the discovery, say, of the amœboid organism in the red discs of the blood is a more important matter than elaborate clinical diagnosis of ague. Dr. Finlayson was regarded by the profession and the public in the West of Scotland as a physician pre-eminent in diagnosis, one in whom every confidence could be placed. To his knowledge of medicine he added great learning, and was therefore a faithful disciple of Sir William Gairdner. It is said that his contributions to medical literature number about 150, and they range well nigh over the whole field of medicine. One of his more important works is an "Account of the Life and Works of Meister Peter Lowe, the Founder of the Faculty of Physicians and Surgeons of Glasgow." Dr. Finlayson was President of the Faculty from 1900-1903. He was a typical Scotchman, of quiet manner, cautious and careful in what he did, and possessed of great patience and perseverance. J. T. M.

District Medical Dispensaries in Glasgow.—At a public meeting convened on the 12th inst. to consider this question, Lord Provost Bellsland stated that the population of the district in which it was proposed to establish a medical dispensary was between 60,000 and 70,000, mostly of the working class. The sum of £3,000 was required, of which £670 had been subscribed. The dispensary would be similar to those in other districts, but special attention would be directed to the treatment of diseases of women and children, thus endeavouring to mitigate the terrible evil of infantile mortality. On the motion of Dr. Carswell, supported by Drs. Russell and Chalmers, it was agreed to establish the proposed dispensary in the Anderston district.

BELFAST.

Death of Mr. May, Rathfriland.—One of the oldest medical men in Ulster passed away last week, Dr. Joseph May, J.P., of Rathfriland, co. Down. He was born more than ninety years ago near Dromara, co. Down. He took the L.A.H. in Dublin in 1844, and the double qualification of the Edinburgh Colleges in 1860, and practised in Rathfriland till 1881, when he resigned the dispensary, and was succeeded by his nephew, Dr. James May Elliott, who still holds it. For the last twenty-five years he interested himself in his magisterial duties, and in the affairs of the Presbyterian Church, of which he was an ardent member.

The Typhoid Outbreak.—A special meeting of the Public Health Committee was held last week to consider what action should be taken in view of the results of investigations as to the cause of this outbreak. As was reported some weeks ago, the cases could be traced pretty clearly to a certain milk supply, and several cases of typhoid were found among the customers of this dairy outside the city. But on inspection and examination nothing whatever could be discovered wrong with the dairy, which seemed indeed to be almost a model one. No sickness was found on the farm, and the milk, water, and drains were all tested with negative results. On further inquiry it was found that a woman who was occasionally employed to milk had been ailing some months ago, apparently with pneumonia. A sample of her blood was obtained, and gave a marked positive reaction with Widal's test. The milk had now been "withdrawn from public sale," but till a few days ago, and for many days after it was suspected, it was still freely sold, the dairy proprietor acting on the advice of his solicitor that there was no case against him when the examination of the milk gave negative results. The facts have now become public property, and have raised a storm of indignation. Of course, the public attribute the delay in cutting off the suspected milk supply to the want of a properly qualified medical officer of health, and though no doubt there were legal and technical difficulties in the way, it is hard to believe that a capable and energetic medical officer would have sat quiet for two or three weeks, while some score of cases of typhoid were notified each week, all among the customers of one dairy!

The Health of the City.—The agitation against the recent appointment of an inexperienced man as medical officer of health proceeds vigorously. The Chief Secretary for Ireland has consented to receive a deputation from the Citizens' Association with regard to the matter, and it is intended to demand a Royal Commission to make full inquiry. To show the strength of feeling on the question, it is worth reporting that one gentleman has offered £100 towards a guarantee fund for any necessary expenses incurred in this movement, and has said that if expenses run into thousands he will give £500.

Failure to Notify.—Dr. D. C. Smiley was summoned last week for failure to notify a case of typhoid which had been under his care for nearly two months. There was no appearance for the defence, and the maximum fine of forty shillings was imposed.

Our Edinburgh correspondent informs us that Dr. Andrew Carnegie has bestowed on the University of St. Andrews a gift of £22,500. £10,000 of the sum is to be devoted to the extension of the University library, and the remainder to the Physics laboratory in University College, Dundee.

LETTERS TO THE EDITOR.

THE COMING ELECTION TO THE GENERAL MEDICAL COUNCIL.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I shall be glad if you will permit me to announce that Mr. J. Rutherford Morison, F.R.C.S., of Newcastle-on-Tyne, in response to many requests, has reconsidered his determination not to stand for election, and will now be a candidate. His address to the profession will be issued shortly.

I am, Sir, yours truly,
ALFRED COX,
Hon. Sec. to Election Committee.

Cotfield House, Gateshead, October 12th, 1906.

THE DECLINING BIRTH-RATE.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—I assure your correspondent "Obscure Practitioner" that I in no wise confound the British empire with the British nation. I am quite alive to the facts enumerated in his letter, except that I was not acquainted with the identical statement that "there is room for our surplus population for the next 500 years." It would seem to me that a calculation of this profundity, to ensure its accuracy, must require the combined intellects of mathematicians, statisticians, historians, and obstetric authorities. However, accepting such as literally true, I nevertheless apprehend that it is the duty of a State analogous to a parent towards children to make adequate provision for its offspring; hence, that the health of the British nation is of primary, and the vastness of our empire of secondary importance. Let us beware, therefore, pending these 500 years, that we do not in the meantime as a nation long ere that period has elapsed, and before the full development of a fantastic and phantom empire, come to grief in our own home or castle, if we convey to the world that the one idea of the principal function of the British nation is to produce healthy progeny for pastures elsewhere on the globe, and leave the decrepit to multiply within our own shores. Decadence or degeneration would result sooner or later in the disintegration of our entire empire. Nothing, as I have remarked previously, could more speedily effect this than extreme poverty and numerous offspring, without the necessary ways and means to rear them in a healthy moral and physical condition.

I am sorry I misunderstood the term "well-bred" as applied by your correspondent. I thought he used it in a conventional sense, supposing the upper stratum of a community would provide healthier stock than the lower. I called attention to a statement of great import in your correspondent's letter, viz., where he advances the proposition that the unhealthy are multiplying out of proportion to the healthy. I hold this to be a separate proposition to a declining birth-rate, because the one might take place independently of the other. For example, if the birth-rates were to rise, and at the same time a greater proportion of the unhealthy were to multiply, decadence would still go on, hence decadence and increasing birth-rate might co-exist. It is vaguely said of statistics that they may be made to prove anything. The true meaning of this is that different observers draw different inferences from the same statistics. Now, if these inferences are equally probable and somewhat contradictory, instead of proving "anything" they prove nothing.

I am, Sir, yours truly,
CLEMENT H. SERS.

Brighton, October 13th, 1906.

MEDICAL REFORM.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—One of the reasons why the doctors are suffering as they do is the fact that the public can go and get the article gratis—the real article, high quality for nothing at our hospitals. Naturally, what we can get for nothing we don't esteem very highly, and nowadays with all classes the question is what hospital to go to where the best can be got. The question that naturally arises is, Why do hospitals do this? What is their reason or object? The reason a business man would give is simply that "if he can get the doctors to work for nothing at hospitals, just see what we, the public generally gain by it. We can leave the ordinary doctors alone. They are not up to much, and we can do without them." The question the doctors are beginning to ask themselves is whether they may leave the public alone, or whether they are justified in opposing this system which is steadily ruining them.

Some may take the view that the hospitals may be left alone, as they feel sure they won't get money to carry on with; and probably the men who work at hospitals for nothing may find out that it doesn't pay. Of course, if hospitals don't work as advertisements that pay, that method of advertising will be dropped. So some think it best to leave hospitals alone, and do nothing to keep them. A good many are going from bad to worse, and as the poor are provided for out of rates and taxes, hospitals will die out, like many other of our old charity institutions. That's the view that some take. One of two things must happen. We may slowly degenerate and come to the state in which China has been now for many years, and the doctor may lapse into the blind huckster of charms with a dog and a stick to help him; or the public may have sense enough to see that they will suffer and go down to the miserable condition of an effete people. Would it not be best, sir, if this question is going to be handled by the doctors generally, that they let it clearly be understood they have one object in view, and that, before all others, namely, the good of this our country, and the people who live in it? I am, sir, yours truly,

CANTABRIGIENSIS.

OBITUARY.

JAMES HANCOCKE WATHEN, M.R.C.S.E., L.R.C.P.EDIN.

WE regret to hear of the death of Mr. Hancocke Wathen, on the 5th inst., at Stoke Bishop. The deceased gentleman, who was a native of Fishguard, in South Wales, had resided for many years in Bristol, where he practised as a surgeon. He was trained at University College and the Royal London Orthopædic Hospital, and took his degree of M.R.C.S.Eng. in 1865, and two years later the L.R.C.P.Edin. He was appointed assistant house-surgeon at the Bristol General Hospital. Subsequently he served as house-surgeon to the West London Hospital, and Orthopædic surgeon's assistant at University College Hospital. At a later date he practised in Clifton in conjunction with Dr. Steele, though the partnership was dissolved some years ago. For a long period up to 1901 he filled the position of Medical Officer to Clifton Wood Industrial School, and another institution with which he was associated was the Skin Dispensary. He also took an active part in the Volunteer movement, and he retired from the Gloucestershire Artillery Volunteers with the rank of Surgeon-Captain. It was in comparatively recent years that he became identified with civic affairs. Mr. Wathen, who married a daughter of the late Sir George Edwards, had not been in robust health for some time past, but he was well enough to be in the city a few days ago.

INSPECTOR-GENERAL E. R. H. POLLARD.

WE regret to record the death of Inspector-General E. R. H. Pollard, of the Royal Naval Hospital, Chatham. He had been a member of the medical department of the Navy for nearly thirty years. As surgeon on his Majesty's ship Boadicea he landed with the Naval Brigade during the Zulu War of 1879. He also served with the Royal Marines in Egypt in 1882, and was present at the Battle of Tel-el-Kebir. For these services he received the Zulu medal, and the Egyptian Medal and Clasp and the Khedive's Bronze Star.

SPECIAL ARTICLES.

THE LONDON MEDICAL EXHIBITION.

(Concluded.)

It is now possible to have Droitwich Baths at home, for Messrs. Weston and Westall put up the evaporated salt into bags so that for baths to be taken away from the town. Nestlé's Company, besides their well-known tinned milks and Milo Food, have just started a dairy in London, under the style of the Ideal Dairy Company. They were exhibiting the chief feature of this departure, namely, bottles of fresh milk which will be delivered at houses at the same rates as that usually supplied in cans. The stopper of each bottle is sealed with a disc when the milk is sent out, so that no contamination can occur in transit. A novel substitute for tea, coffee, and cocoa was on view. Under the name of Ovaltine, a combination of malt extract, fresh eggs, milk, and converted cocoa—to which is added Lecithin—is made up, and is surprisingly palatable and refreshing. Dr. Wander, of Berne, who has recently brought the preparation to this country, has also a Dry Crystallised Extract of Malt, which seems to present a useful form for administering this favourite remedy. Messrs. Seabury and Johnson's Thermogene and surgical dressings have a high reputation, and their ingenuity in finding ways of aiding the surgeon to preserve asepticity with the minimum trouble are endless. Even ligatures of all sorts of materials, and needles ready threaded with sutures, are supplied ready sterilised in separate boxes for each suture or ligature. Some of their new plasters are well worthy of trial. Dr. Theinhardt's Food Co., Ltd., have recently started business in England, and they have a variety of useful foods to offer prepared chiefly from Professor König's formulæ. They all seem to be of good nutritive value. Pumuline may not be known to everybody, but it is a pleasant essential oil, made by Messrs. Stern and Co., of Manchester, into soaps, ointments, and various lotions. Messrs. Parke, Davis and Co., as usual, are quite in the front of progressive pharmacy; indeed, they had a bewildering show of new and old friends. Their Typhoid Agglutometer, whereby any practitioner may do his own Widal's reaction at home, with nothing but what is supplied in the case, and without any skill in bacteriological technique, is an exceedingly ingenious apparatus. Among the publishers, Messrs. Baillière, Tindall, and Cox had a capital display of new books and new editions, their "University Series" especially meeting with widespread attention by the uniformly high level of success attained by each volume. It is difficult to say which of their deservedly popular manuals is the most esteemed. Messrs. W. B. Saunders had many of their American medical books on view, and Messrs. Cassell and Co., Messrs. Constable and Co., and the Oxford University Press all had a brave show of good books.

The invalid specialities of Messrs. Brand and Co. were old friends to most of the visitors, but one noted that the firm are well up to the requirements of the times, and that they now have a meat-juice of high grade, and various peptone preparations to suit all digestions. Of Bovril it is almost supererogatory to speak; everyone knows Bovril; but it may be news to some that Bovril lozenges, Bovril staminoids, and Invalid Bovril are prepared for various special purposes. Moreover, all kinds of concentrated forms of meat are sold by the firm for travellers, soldiers, and those who go exploring. Thomas Christy and Co. had an interesting stall. Glycothymoline greeted one with its usual fragrance, and Christy's surgical apron and dressings were there in their glory. There were numerous new compounds on view—Lysoform, a formaldehyde disinfectant, Alphozone, a harmless antiseptic, Adnephrin, Fluor-Rennin, a new drug containing fluorine, Antitussin, and many others testifying to the resource of the makers. Burgoyne, Burbidge and Co. were showing a variety of elegant preparations of emulsions of cod-liver oil combined with drugs, such as creosote, hæmoglobin, and glycerophosates; Zotal, a useful miscible disinfectant; Xeroform, an odourless substitute for iodoform; Unguentum Heyden, a colourless form of mercury for inunction; Omorol, a novel silver compound, and many other interesting exhibits. Cadbury and Fry both had their delicious chocolates and cocoas on view, and neither of these firms needs any recommendation except that of memory. Anæsthetics recall the name of Duncan, Flockhart and Co., but it may not be so generally known that they also supply preparations of all kinds of other drugs. Their Sapo Antisepticus Aethereal is an ethereal soap combined with 1-1000 iodide of mercury, and their Baumol soap forms a capital base for any medicament to be used in the toilette of the skin. Keen, Robinson and Co. had a new thing in Waverley Oats, and Robinson's Groats and Barley were there lest they should be overlooked after many years' service. The alkaloid products of the Abbot Alkaloidal Company showed what can be done by brains to make drugs portable, tasteless, and efficient; their granules and tablets being marvels of neatness. Novocain, a new substitute for cocaine, which can be sterilised by boiling and is of low toxicity, was shown by the Saccharin Corporation, Ltd.; and Angier's emulsion and throat tablets by the Angier Chemical Company. Messrs. E. Merck were introducing a large number of promising goods—drugs, serums, and various chemicals. Stypticin, a soluble hæmostatic and sedative for intra-uterine use, we had not met with before, and Bromipin, Iodipin and Dionine all invited experiment, so promising did they seem. Plasmon has now assumed many forms, and International Plasmon, Ltd., had much to show, especially a Plasmon luncheon-basket that looked very inviting. Messrs. Allen and Hanbury had a noble show of instruments of all sorts and descriptions. A peculiarly neat instrument, combining the purposes of a pair of scissors and a frænum refractor, should come into use for circumcisions, and self-retaining retractors for abdominal and other work were shown in great variety. Messrs. Ingram and Royle had a fine lot of mineral waters from nearly all the spas of Europe, and also a show of pastilles. Diuretin, Tannalbin, and Ichthalbin were amongst Messrs. Knoll and Co.'s fine products, and their dermatological preparations—Lenigallol, Iodoform Albuminate, Eugallol, and Anthrasol—are as elegant as they are ingenious. So, too, with Messrs. Newbery and Sons, who presented a number of the useful manufactures of Messrs. Warner and Co., all very interesting. Antiphlogistine was the sole exhibit of the Denver Chemical Company, and it is already too well known to need any particular description from us. We may, however, add as something new concerning it, that Emeritus Professor Piffard, of New York University, said at a recent meeting of the Dermatological Society that "he had obtained the most benefit in treating X-ray burns with Antiphlogistine." Castor oil in powder should be a blessing to medical men with young and refractory patients; it, and powdered cod-liver and other oils, presented by Mr. Rudolph Demuth, invited trial. Finally, there was Messrs. George Bach and Co.'s "G.B." Diabetes Whisky, which is one of the few prescriptions patients never object to. We could continue our description of the products exhibited, doing but little justice to each, we fear, for several columns more; but we have probably said enough to make medical men realise that it will be well worth their while to see next year's exhibition.

THE DUBLIN UNIVERSITY COMMISSION.

The appendix to the First Report of the Dublin University Commission (*a*) contains much more matter of interest than it is possible for us to deal with in the space at our disposal. The present volume consists entirely of statements and returns furnished to the Commissioners by various persons and bodies interested in education,—such as the Provost and Fellows of Trinity College, the Professors of Trinity

(*a*) "Royal Commission on Trinity College, Dublin, and the University of Dublin. Appendix to the First Report." Dublin. H. M. Stationery Office, 1906. Price 1s. 4d.

College, and Dublin University, the Synod of the Church of Ireland, the Bishops of the Roman Catholic Church in Ireland, and the General Assembly of the Presbyterian Church, and others.

It will be remembered that the terms of reference of the Commissioners are very wide, but their duties centre round the main questions:—(1) The possibility of the solution of what is known as the Irish University question on the basis of Trinity College or the University of Dublin. (2) The need for and nature of internal reform in Trinity College. As to the first question, it is obvious that if any settlement of the university question is to be arrived at, there should be some possibility of an agreement between Trinity College on the one hand and the heads of the Roman Catholic Church on the other. The views expressed in the Report make clear the improbability of any such agreement. On the one hand, there is practical unanimity among the Provost, Fellows, and Professors of the College against any scheme of planting side by side with Trinity College another college in the University. On the other, the Roman Catholic Bishops declare that "the Catholics of Ireland would be prepared to accept any of the following solutions:—(1) A university for Catholics; (2) a new college in the University of Dublin; (3) a new college in the Royal University; but that on no account would they accept any scheme of mixed education in Trinity College, Dublin. As the latter is the solution approved of by the staff of Trinity College, the hopelessness of the situation is obvious. If the Commission can find a way through the impasse, they will well have earned the gratitude of the country.

As regards the second point, it is probable the Commission will find their task easier. Every one is agreed that the present Fellowship system—election for life on the results of a competitive examination held in a few subjects—is bad, and out of date. Most of the suggestions put forward are on the lines of granting a certain number of fellowships for research work, and of appointing a number of readers for short periods.

The present system of government of the Colleges by the Provost and seven Senior Fellows—comes in for very general condemnation. It is suggested that the place of the present Board should be taken by an elective body, on which should be represented not only the Fellows, but also the Professors, and the general body of graduates.

The professors of the medical school make strong pleas on behalf of further provision for research by young graduates. This problem is more difficult in Dublin than elsewhere, since nearly all the Dublin graduates are poor men who cannot engage in research work unless not only the actual expenditure is met, but a means of livelihood provided for them during the time they are occupied in the work.

The returns of income and expenditure—hitherto kept secret with the greatest care—will attract attention. The total income during last year was £70,932 6s., the expenditure £69,355 14s. 4d. The salaries of the Provost and Fellows accounted for £21,000, and the expenses of the medical school for £5,764, the divinity school £3,072, the law school £712, and the engineering school £1,394.

REVIEWS OF BOOKS.

BROADBENT ON HEART DISEASE. (a)

SIR WILLIAM BROADBENT has entrusted the preparation of this fourth edition of his well-known work to his son, Dr. John Broadbent, who has revised and re-written several chapters. Sir William Broadbent has, however, re-read the complete work in its passage through the press, adding his valuable matured experience to the chapters on angina pectoris, and on functional diseases of the heart, which in the past have caused the work to be referred to as the most reliable text-book on the subject of which it treats. This revised edition may be taken as presenting a clear statement of the subject in brief, simple language, without either "padding" or the recitation of superfluous cases (which makes the reading of many present-day books a wearisome and unprofitable labour), and as a trustworthy, valuable, and suggestive guide, founded on long experience, accurate observation, and a thorough knowledge of the literature of the subject.

We would like to have had a still more generous treatment of the subjects dealt with in Chapters XXVI. and XXVII.—viz., Functional Affections (so-called) and Disorders of Rhythm of the heart, for it is here that practitioners would eagerly look for enlightenment from a long and large experience such as the author's. What a chapter, for instance, might be written on cardiac pain!

On page 14 will be found this statement: "The systolic murmur heard at the apex always signifies more or less regurgitation through the mitral orifice." That the author intended to qualify this more than he has done is evident from the following (page 15): "A pulmonic or aortic systolic murmur may be conducted to the apex, but it will be of diminished intensity and will not, as a rule, be conducted towards the axilla." We heartily recommend this work to all practitioners who wish a thoroughly trustworthy, readable, and scholarly monograph on cardiac disease.

(a) "Heart Disease and Aneurysm of the Aorta." By Sir William Broadbent, Bart., K.C.V.O., M.D.Lond., F.R.S., D.Sc., LL.D.Edin., F.R.C.P., Physician in Ordinary to H.M. the King, and to H.R.H. the Prince of Wales. Consulting Physician to St. Mary's Hospital and to the London Fever Hospital, etc., etc.; and John F. H. Broadbent, M.A., M.D.Oxon., F.R.C.P., Physician to Out-Patients, St. Mary's Hospital. Assistant Physician to the London Fever Hospital. Fourth Edition. Pp. 479, with 39 illustrations. London: Bailliere, Tindall, and Cox. Price 12s. 6d. net.

"THE EDINBURGH MEDICAL JOURNAL." (a)

THIS half-yearly volume contains no less than forty-four original communications, many of which are of considerable interest. Some of them have already been noticed in our weekly "Summary," and, in consequence, it is unnecessary to make mention of them here. Perhaps the most striking paper of the entire number is the abstract by Ford Robertson of his Morison Lectures on the Pathology of General Paralysis of the Insane. In it he gives a short account of his investigations into the matter, and states his grounds for believing that the cause of the disease is a diptheroid organism. Another interesting paper is that by Dr. Franze on "Estimation of the Functional Power of the Heart by the Aid of Ortho-Diagraphy." Dr. Franze has lately contributed papers on the same subject to other journals, and may be regarded as the pioneer of the method in this country. In his article he lays stress on the importance of an estimate of the actual size of the heart by means of X-rays, and points out that, as ordinarily examined, the cardiac shadow is necessarily much larger than the size of the organ itself. He then describes and figures Moritz's orthodiagraph, an instrument which has been devised to overcome this difficulty, and points out that by its aid definite information concerning the size of the individual cardiac chambers can be obtained. Dr. Llewelyn Jones contributes an important clinical paper on Spondylitis Deformans, and sums up the features of the syndrome as follows:—(1) Greater or less immobility of the entire spine or part of it, without marked pain on pressure or concussion; (2) Backward bowing of spine, especially of chest region, causing the head to be thrown forward and the chin depressed; (3) Weakening and possible atrophy of muscles of rump, neck, and extremities; (4) Various irritative phenomena, as paræsthesia, pain in neck and back muscles, etc. This paper is well worthy of careful study, and throws light on a condition which is, as a rule, very inadequately discussed in standard works. Space forbids us to more than mention Moynihan's paper on Courvoisier's law and Fowler's on Osteogenesis Imperfecta. We recommend the volume to all those who do not take the journal monthly.

(a) "Edinburgh Medical Journal." Vol. XIX. Edinburgh and London: Young, J. Pentland. 1906.

ANATOMY. (a)

Considering the large size of this text-book, and the number of other excellent works of the same nature it has to compete with, it is undoubtedly a matter of congratulation for the editor and his collaborators, that a second edition should be called for within four years of the first. The general appearance and style of the volume remain unchanged, but considerable alterations in detail have been introduced, and many illustrations have been added, so that on the whole the edition compares most favourably with the preceding one. In the section on Osteology the outline markings of muscular attachments on the bones have been left out in the illustrations. This is probably partly due to the fact that many of those figured in the first edition were incorrect, and from that point of view the change is a welcome one, but we regard it as a mistake not to have substituted more reliable drawings, instead of omitting the outlines altogether. We are told, indeed, in the preface that some special work has been done in the mapping out of muscular areas, but the illustrations given are included in the section on Myology. Considering that many students make a practice of "learning their bones" from a systematic text-book, and of learning the muscles either from observation in the dissecting-room, or from a smaller work on regional anatomy, we look upon this arrangement as a mistake, although, indeed, the wood-cuts of the bones have gained considerably in appearance thereby. The radiographs of the foetal hands and feet which have been introduced to illustrate the description of the ossification of those parts, are an interesting addition, and it seems almost a pity not to have made more extensive use of this means of illustration. Before leaving the section on Osteology we would like to call attention to the figure of the temporal bone on page 116. The perspective in it appears to us to be faulty, and it at any rate falls far short in artistic merit of the other figures of the same bone. The section on Arthrology has been greatly improved by the use of colour in the engravings, and is now quite up to the standard of the rest of the work. In figure 234 on page 299 the popliteus muscle is not shown quite correctly, but otherwise we have no fault to find, while we may add that the figures illustrating the ankle joint, and the tarsal and metatarsal ligaments are in every way most admirable. We wonder if the author has ever seen anything quite so perfect in the course of actual dissection.

We have already adverted to the figures that have been introduced into the section on Myology to illustrate muscular attachments, and need not further refer to them. The use of colour for the muscles adds greatly to the figures in this section, and makes them much easier to understand.

There is but little change in the sections on the Nervous and Vascular systems. The description of the Central Nervous System from the editor's pen still continues to be the best of its kind in the English language. It is both clear and complete, and leaves little to be desired. Incidentally, we may remark that the use of colour would be of great assistance in showing up the relations of the peripheral nerves as shown in Dr. Paterson's section, and that the figure of the superior maxillary nerve on page 682 might have been made more elegant before including it in the present edition. The chapter on the Urogenital, or, as the editor now prefers to call it, the Urinogenital system, has been considerably improved by the addition of new illustrations, and by some new matter in the text. It still shows, however, a fault that was most noticeable in the first edition, and that is this repetition of figures. Throughout the whole book this repetition is indeed found—*e.g.*, figure 344 and figure 655 appear three times each throughout the volume, but in no section save the one now under comment does one meet with the same illustration repeated within a few pages of its previous appearance; in fact, within the compass of eighty pages we find at least eight individual figures repeated. The comment on this fact is obvious. We are glad to notice that some reference is made to the renal fascia, but are surprised to notice that the index does not contain any record of it. A little more detail is given concerning the prostatic capsule, but we think that the writer might have been a little more dogmatic in defining and applying terms; in fact, he might have given an anatomic and much-wanted lead instead of avoiding, as he does, the use of terms. A disposition to "hedge" is shown elsewhere, for the writer has apparently not made up his mind definitely as to the position of Bartholin's glands. He figures these indeed superficial to the triangular ligament, but does not state definitely in the text that that is their position, although he must surely be aware that it is a disputed point. But little change has been made in the article on the ductless glands, except for a little more extensive information on the Parathyroids, and on the Carotid and Coccygeal glands. A curious slip has crept into the description of figure 877 on page 1,221. It is apparently intended to show the relations of the coccygeal body to the middle sacral artery, but instead of the word coccygeal the word carotid has been used altogether eight times. Some other slips and misprints might be referred to, but they are mostly unimportant. We were interested to notice in this section two references to the Chromaffin system of the body. They show that the editor not only believes in being up to date, but also in keeping well abreast of recent research in the record of facts to be brought before students. The article on applied anatomy has been amplified, and has had one very important illustration added to it, namely, a drawing of a dissection of the spleen from the side. This is a most beautiful picture, and of high teaching value. We wonder that the editor considers it necessary or advisable to retain this brief chapter on such an extensive subject as Surgical Anatomy when there are now so many excellent monographs on the subject. Looked at as a stimulant to further reading, however, it perhaps justifies its retention.

(a) "Text-Book of Anatomy." Edited by D. J. Cunningham, F.R.S., Professor of Anatomy, University of Edinburgh. Second and thoroughly revised edition. Edinburgh and London: Young, J. Pentland. 1906.

ABDOMINAL OPERATIONS. (a)

This book on Abdominal Surgery includes only those operations which are common to both sexes. No gynæcological operations are described, and operations on the kidney or bladder, and operations for hernia are not included. The book consists of five sections, the first containing short chapters on Bacteriology, Preparation and After-treatment, the Treatment of Peritonitis, etc., the other sections containing descriptions of operations on the Stomach, Intestines, Liver, Pancreas, and Spleen. Throughout the book, while all the recognised operative methods are well described, there is a definite sense of individuality which is unusual in books on operative surgery. In many instances, not only is the operation described, but a clear account is given of the indications for the operation and a table of the immediate results and subsequent history is given. In the treatment of gastric hæmorrhage, Mr. Moynihan lays down as the safest course, the securing of the bleeding point followed by a gastro-enterostomy, but it is evident from the cases quoted that Mr. Moynihan is satisfied that the performance of gastro-enterostomy alone is effectual in checking the hæmorrhage. The description of posterior gastro-enterostomy is admirably clear, and the eight points to be observed sum up the operation well. It might have been better perhaps if the illustrations (pp. 147 *et. seq.*) had been arranged horizontally instead of vertically; as it is, such an expression as "the left end of the incision" (p. 150) is meaningless. It is interesting to notice than Mr. Moynihan considers the operation of pyloroplasty an unsatisfactory one. In the description of operations for cancer of the stomach, a good account is given of the gastric lymphatics, and the suggestion that, in partial gastrectomics, all idea of end-

(a) "Abdominal Operations." By B. G. A. Moynihan, M.Sc., Lnd., F.R.C.S. Philadelphia: W. B. Saunders and Co. 1905. Pp. 670.

to-end anastomosis of stomach and duodenum should be given up, is of great value from the point of view of free removal. In the section on Intestinal operations, Mr. Moynihan takes a definite stand on the use of mechanical appliances for anastomosis; "the use of mechanical appliances is no longer necessary, these have played their part in the development of surgical work, and it is now time that their use should be abandoned." Mr. Moynihan advocates union by a double row of continuous sutures, and the details of this method are repeated on several occasions. In the chapter on Obstruction a great point is naturally made of the necessity for emptying the gut above the obstruction, and an ingenious method of draining through a tube upon which the intestine is drawn, is described. In a few words Mr. Moynihan emphasises a rule which is now well recognised, *vis.*, "there are few rules so binding upon the surgeon as that which prohibits the resection of growths and end-to-end anastomosis of the large intestine in cases of acute obstruction." In the section on Liver Surgery, the method of rotation of the liver, first described by Mayo Robson, is extensively employed. The immediate closure of the gall bladder after the removal of gall stones is "unequivocably condemned" but cholecystectomy is advocated in cases of hydrops or empyema of the gall bladder consequent on impaction of a stone in the cystic duct. In the operation of cholecystenterostomy Mr. Moynihan advocates a lateral anastomosis between the two limbs of the intestinal loop. On the question of infection of the gall bladder from the intestine after this procedure Mr. Moynihan is not positive. On p. 569 he says: "The intestinal contents are in this way short-circuited, and there is no risk of infection of the gall bladder from the intestine"; while on p. 611 he says: "the risk of this infection is lessened considerably, but is not abolished." The section of the Surgery of the Pancreas and Spleen is an admirable summary of the most modern work in this region. The book, as a whole, is a very valuable contribution to Abdominal Surgical literature, and though of a formidable size, is, by reason of its clear style, easy reading, while the wealth of admirable illustrations makes it easy to follow the steps of the operations.

CLINICAL BACTERIOLOGY. (*a*)

ALTHOUGH under an extended title, this constitutes the second edition of Dr. Emery's excellent "Handbook of Bacteriological Diagnosis for Practitioners." Manifestly it has served its purpose as a simple, practical guide to practitioners lacking in pathological technique, and yet conscientiously desirous of availing themselves of the most reliable aids to clinical precision, and in this new and amplified form will be found ample information to place the busy doctor abreast with the fast-moving times. The hæmatological portion is almost entirely new. It is on much the same lines as the purely bacteriological section. Conditions requiring examination are explained, methods detailed, deductions indicated, and cautions given. Dr. Emery wisely points out that "the results of a blood examination are similar to those of other physical examinations; they are easy to obtain, but often very difficult to interpret."

The work is admirable in that it gives complete and thoroughly practical information. It is just what the work-wearied general practitioner requires to help him in the duties and difficulties of his profession. Every page bears evidence of very thorough revision, and there is a conspicuous up-to-dateness everywhere manifest. There is a very lucid description of the circulation of the opsonic power of the blood, full particulars regarding lumbar puncture, and a description of the best means of demonstrating Schaudimi's spirochæte of syphilis. The section on Cyto-Diagnosis, although short, is explicit, and well presents our reliable knowledge regarding this necessarily limited means of investigation. The illustrations throughout are most helpful. The work has been well planned, faithfully executed, and will be widely appreciated.

(*a*) "Clinical Bacteriology and Hæmatology for Practitioners." By W. D'Este Emery, M.D., B.Sc.Lond., Clinical Pathologist to King's College Hospital, and Pathologist to the Children's Hospital, Paddington Green. Pp. 240, with 10 plates and 47 figures. London: H. K. Lewis. 1906.

LITERARY NOTES.

THE "TIMES," THE PUBLISHERS, AND THE BOOKSELLERS.

A GREAT commotion has manifested itself in the book trade between the Publishers' Association and the proprietors of the *Times* newspaper, and a crisis has now arisen in which neither side is prepared to give way. In its ultimate issue the medical profession is only indirectly interested, as the question of medical books has not arisen. Their price of publication has always been and must necessarily be high when compared with fiction, on account of the costly nature of production and the limited field of readers. The fight relates primarily to novels and historical literature, in which the author, publisher, bookseller, and the public generally are greatly interested.

LAST year the *Times* started a book club, having for its objects the securing of additional subscribers and advertisements for this newspaper. That the *Times* was sadly in want of fresh advertisers is shown by the fact that in its columns will now be found a host of quack advertisements that, prior to the American control, were excluded and condemned by its editors. By the tempting offer of a book club, from which the public were promised the supply of any number of books immediately on publication, and the subsequent sale to them of such books at a price far below that possible by the bookseller, the *Times* netted a considerable number of new subscribers.

"So far so good" as between the newspaper and its readers; but the bookseller has something to say. He tells the publisher that the *Times* has ruined his business, and that he cannot now sell books, as his former customers can get them at half their nominal value, and that if the system continues their shops must be closed, as their occupation has gone. The publisher is thus faced with the startling problem that the thousands of allied tradesmen in all parts of the kingdom to whom he has looked for the disposal of his wares, will be no longer available, and that a gigantic monopoly will result in disaster all round.

EACH side in the contest protests that the fight is in the public interest, which is, of course, nonsense, and the crux resolves itself into one of endurance—a strike, in fact, the end of which it is impossible to forecast. For ourselves we can only express regret that the *Times* has stooped to the arena from its once deservedly lofty position as "the leading newspaper of the world." In that capacity it surely had ample scope, while in the mundane condition of "income" public opinion voted it prodigious. Such being admitted, we submit that it was scarcely worth competing as a second-hand bookseller to ruin the thousands of that ilk.

AT a meeting of the master, wardens, and court of assistants of the Society of Apothecaries of London held at their hall on Tuesday, the honorary freedom of the society was conferred upon Alderman and Sheriff Crosby, who is a licentiate of the society. The master, Mr. E. Parker Young, and wardens subsequently entertained at dinner Dr. Crosby, the members of the court of examiners, the deans and wardens of the Metropolitan schools of medicine, and a large number of the livery of the society.

MR. HENRY S. WELLCOME, who established the Wellcome Research Laboratories at the Gordon Memorial College, Khartum, three years ago, has sent a donation of fifty guineas towards the endowment fund of the London School of Tropical Medicine.

Medical News in Brief.

Royal College of Surgeons of England.

At a quarterly meeting of the Council held on Thursday last, Mr. Henry Morris, President, in the chair, the annual report of the Council to be presented at the meeting of Fellows and Members of the College on November 15th was approved and adopted. The report contains a record of the work of the College in its various departments during the past collegiate year. Besides dealing with the reports of several committees, it contains articles dealing with the length of the medical curriculum, the position of the college as a qualifying body, a proposal to institute a diploma in tropical medicine, and the working of the Midwives Act (1902). During the year with which the report deals, the following diplomas have been issued: Membership, 423; Fellowship, 42; Licence in Dental Surgery, 87; and the Diploma in Public Health, 33. The re-decoration of the museum, begun in 1903, has been completed at a cost to the College of over £1,000. The presentations to the museum have been well kept up, and the donations to the library include many interesting pamphlets and volumes of MS. writings. During the past year the number of readers in the library has been 11,267. The deaths of 20 Fellows and 264 Members of the College have been reported.

The two following members of the College, having passed the required examinations and conformed to the bye-laws, were admitted Fellows of the College: David Kirkpatrick Coutts, M.B.Lond., St. Thomas's Hospital; and Robert Rutson James, L.R.C.P.Lond., St. George's Hospital. Diplomas of Membership were granted to: George Ford, Toronto University and University College Hospital; and Wolbert Ernest McClellan, Toronto University and London Hospital. Diplomas in Dental Surgery were issued to the following candidates: Reginald Hudson Astbury, Birmingham University; William Alfred Helyar, Guy's Hospital; Ernest Gibbon, Durham University; Percy Vivian Giles Pedrick, Guy's Hospital; and Charles Cook Pooley, Middlesex and Royal Dental Hospitals.

An honorarium of £100 was presented to Mr. William Pearson, the prosector in the museum, "in recognition of his valuable work, and of his having completed fifty years in the service of the College."

It was decided to publish a revised edition of Part I. (Man) of the Osteological Catalogue. The loan of museum specimens to the Army Medical Department for examination purposes was renewed for another year. Mr. Godfrey Alan Walker, until lately a student at Epsom College, and now at the London Hospital, was nominated by the Council as the fourteenth Jenks Scholar.

The Royal College of Surgeons in Ireland and the University of Aberdeen Celebrations.

The following is the text of an address presented by Mr. Henry R. Swanzy, President of the Royal College of Surgeons in Ireland, in the name of the College, on the occasion of the recent quater-centenary celebrations of the University of Aberdeen

PRÆCLARÆ UNIVERSITATI ABERDONENSI REGIUM COLLEGIUM CHIRURGORUM APUD HIBERNOS, S.P.D.

Vehementer vobis, viri illustres, gratulamur quod quattuor sæculis prospere decursis quintum iam auspiciis faustissimis incohatis.

Universitas Aberdonensis cum primum orta est anno post Christum natum MCCCCXCV in ipsis incunabulis Facultatem Medicinæ longe in his finibus antiquissimam instituit cuius rei gratia sit conditori vestro sagacissimo Guilelmo Elphinstone.

Unde est orsa in eo perstitit atque nunc perseverat. Per annos iam quadringentos hæc regna, imperium Britannicum, cuncti denique homines Universitat vestræ Scientiam Disciplinamque Medicam auctas fotas ornatas gratis animis assignarunt et assignant.

Anatomiam Activam, quæ dicitur—studium arti quam præcipue nos colimus coniunctissimum—usque ab anno MDCXXXII. auccessu optimo exercuistis.

Iuvat referre nomina Professorum et Alumnorum Aberdonensium qui in summam claritudinem rei Medicæ et peritia et exercitatione pervenerunt. Ne taceamus Andræum Moir, Guilelmum Pirie, Matthæum Duncan, Andræum Clarke, quattor denique Gregorios qui de Schola Medica intra muros Academicos condenda tam bene meriti sunt. Plures immo plurimos alios viros insignes memorare liberet, sed finibis certis continemur ultra quos veremur ne iam iam egressi simus.

Restat ut Universitati Aberdonensi totis animis de hac tam felici occasione etiam atque etiam gratulemur et vota dignissima nuncupemus pro perpetua eius incolumitate fausto que novi sæculi initio.

Nomina Subnotabamus,
Henricus R. Swanzy, Præses.
Johannes Lentaigne, Præsidis Vicarius.
Carolus Cameron, Secretarius.

Id. Sext. MCMVI.

North-East London Clinical Society.

The annual dinner of this society was held on Thursday, October 11th, 1906, at the Abercorn Rooms, the President, Dr. A. E. Giles, occupying the chair. After the loyal toasts had been honoured the health of the society was proposed by Sir Halliday Croom, who had delivered the opening address before the members on the same afternoon. The President, in replying, sketched the origin and progress of the society, which, although comparatively young, had yet made its influence felt over a very wide area, and boasted of a considerable membership. Dr. Herbert Powell proposed the toast of the Tottenham Hospital, which was so intimately connected with the life and work of the society, to which Mr. C. Churchill, Vice-Chairman of the hospital, suitably replied. Among the numerous visitors present, including ladies, were Sir William Broadbent, Mr. James Cantlie, Dr. Percy Kidd, Mr. Langton, and the Rev. F. B. Johnston, vicar of Waltham Abbey. An efficient and varied musical programme was provided,

Suggested Outside Hospital Service.

Mr. Wellington held an inquiry at Westminster last week concerning the death of Harold Aitchison, 27, of Walthamstow, a draughtsman, engaged in Victoria Street.

It was stated that the deceased man, who was sitting before his drawing-board, suddenly fell back. Witness caught him in his arms, and sent for medical aid. It was twenty-five minutes, however, before a doctor could be found, Twice witness sent round to Westminster Hospital, but they would not send a doctor or an ambulance. Mr. Aitchison expired in witness's arms.

Dr. Trevor gave evidence that death was due to heart trouble, and the jury returned a verdict accordingly.

Another representative of the firm said he offered to take Mr. Aitchison across to the hospital if only the hospital would lend an ambulance, but this request was refused.

The Coroner: The hospitals are always ready to receive patients, but they cannot supply doctors to the public.

The Foreman: I should have thought that in an emergency case like this a doctor might have been sent.

Dr. Trevor, who is on the staff of St. George's Hospital, remarked that doctors were not sent out by that institution.

The assistant secretary of the Westminster Hospital has since stated that it was a rule of the hospital that their medical staff should not be called to treat cases outside except in cases of dire emergency. On the question of not lending the ambulance the hospital possessed no litter suitable for the purpose.

Quackery in Germany.

In his recently published work on quackery and the means of its prevention, Dr. Henry Graack estimates the number of quack doctors practising in the German Empire at 10,000, without reckoning the vast number of quack dentists. The number of qualified doctors practising in Germany is 31,000.

The New Wing to the Acland Home, Oxford.

A new wing, containing operating and sterilising rooms and open-air balconies, recently added to the Acland Home at Oxford, was opened on Saturday last by Dr. Osler, the Regius Professor of Medicine, who read a congratulatory letter from the Queen. Professor Osler pointed out that a home of this description, erected in memory of Mrs. Acland and Sir Henry Acland, was particularly useful for acute surgical cases and enteric fever. Undoubtedly nervous diseases were increasing, and as a rule they were better treated away from home. There were, moreover, some 3,000 undergraduates at Oxford, and it was right there should be an institution where they could be cared for when ill. A University sanatorium was not necessary, because the home supplied its place, and many of the undergraduates, when need arose, received the benefit of the home.

The Vivisection Commission.

At a meeting of the committee of the British Union for the Abolition of Vivisection the following resolution was unanimously passed and directed to be forwarded to the Home Secretary: "This Committee places upon record its deep regret that no accredited medical representative of the Anti-Vivisection cause has been accorded a seat upon the Royal Commission appointed to inquire into the working of the Cruelty to Animals Act, 1876. This regret is accentuated by reason of the fact that of the medical commissioners who have been appointed, one has been a licensed vivisector continuously since the year 1887, two others have taken out licences to vivisect at various times, and a fourth has expressed himself approvingly of the practices. The Committee are of opinion that in view of the preponderating number of commissioners presumably favourable to the practice who have been already appointed there should be added at least one medical representative chosen from among the anti-vivisectionists in order to ensure confidence among the many thousands of his Majesty's subjects interested in this matter that there will be a full elucidation of facts from the evidence of witnesses on both sides."

Society for Relief of Widows and Orphans of Medical Men.

A quarterly Court of the above Society was held on Wednesday last, Dr. Blandford, president, in the chair; fourteen directors were present. Proposals for membership were read from two medical men, and they were duly elected. Since the last Court, two widows, annuitants of the Charity, had died, one had become ineligible, owing to an increase of income. Of the two who had died, one had received in grants £621 and the other £500, their husbands having paid in subscriptions £52 10s. and £15 15s. respectively. The one who was no longer eligible had received £900, her husband having paid a composition fee of £21, for life membership, at the time of his election. It was proposed to distribute the sum of £556 among the annuitants of this Charity as a Christmas present, each widow to receive £10, each orphan £3, and those on the Copeland Fund £5 each. Six letters asking for relief had been received during the last quarter, but this had to be refused owing to the applicants being ineligible under the by-laws of the Society, relief being only granted to widows of deceased members and to orphans below the age of 16. Any registered medical practitioner, resident within a radius of 20 miles from Charing Cross, is eligible for membership. Further particulars may be obtained from the Secretary, 11, Chandos Street, Cavendish Square, London.

Inquest on an Irish Surgeon.

It was stated at an Holborn inquest on the 12th inst. on Daniel Power, F.R.C.S., 48, Medical Officer of Kildare Infirmary, Kildare, Ireland, who died suddenly in lodgings at Gower Street, W., on Wednesday, that he had visited Harrogate. Soon after returning to London he died.

Dr. Ross, of Harley Street, who made a *post mortem* examination on the body, said the deceased's heart was the largest he had ever seen. It was 130 per cent. too heavy, and weighed 11lb. 2 ozs. The Harrogate waters had the effect of upsetting the stomach, and, added the doctor, practically killed the deceased. Death was due to heart disease. The jury returned a verdict in accordance with the medical evidence.

Bequests to Charities.

The death was announced on the 13th inst. of Mrs. Lewis Hill (widow of Mr. Sam Lewis, the well-known moneylender, who afterwards married Capt. Hill, at Grosvenor Square, London, after a long illness.

Mr. Sam Lewis, when he died, left a fortune amounting to between £3,000,000 and £4,000,000.

Much of this vast sum now goes to charities. His widow received £1,000,000 and a life interest in the remainder of the fortune, but the husband left directions as to the charities which were to benefit at her death.

The will set out the following sums for charities at the death of Mrs. Lewis:—

£400,000 for dwellings for the poor.

£250,000 to the King Edward Hospital Fund.

£100,000 to the Jewish Board of Guardians for relief of the poor and establishing a convalescent home or hospital on the sea coast.

£20,000 to the London Hospital for founding and endowing the Ada Lewis ward.

£15,000 for Maidenhead and Cookham charities.

£15,000 (interest on) for Jewish poor in Dublin.

£10,000 for Ada Lewis wing of Maidenhead Hospital.

£5,000 to Ada Lewis ward of Evelina Hospital for sick children.

£5,000 to Paddington Green Children's Hospital.

£20,000 to the Sisters of Nazareth, Hammersmith.

£10,000 each to Guy's, Charing Cross, St. George's, St. Bartholomew's, St. Thomas's, Consumption and Diseases of Chest, Brighton, Metropolitan, and University College Hospitals.

£5,000 each to the Jewish Soup Kitchen and the Royal London Ophthalmic Hospitals, etc., etc.

One million pounds is thus to be expended by the trustees of the estate.

Half of the remainder of two-thirds of the great fortune is to go to King Edward's Hospital Fund, which has already received £250,000, and the other half to the trustees, who have received £400,000, for establishing dwellings for the poor.

The executors and trustees are Mr. E. H. Davies, Mr. A. Jacobs and Mr. A. E. Sydney.

X-Rays and Ringworm.

The Metropolitan Asylums Board, at their meeting last week considered a proposal to reduce the nursing staff at the Downs School for the treatment of ringworm cases, in consequence of the greater rapidity in the cure effected by the introduction of the X-ray treatment. There will be a saving of £204 in salaries, and £28 per annum in each case for lodgings.

Death under an Anæsthetic.

An inquest was held recently on a man named Parker, whose death occurred at the Bristol Royal Infirmary whilst under an anæsthetic. Dr. Williams stated that deceased visited the institution in order to undergo an operation for fistula. He was given an anæsthetic, but expired before the operation commenced, death being due to heart failure. A verdict in accordance with the medical evidence was given.

PASS LIST.

University of Glasgow.

THE following candidates have passed the second professional examination for the degrees of M.B. and Ch.B. in the subjects indicated (A., Anatomy; P. Physiology; M., Materia Medica and Therapeutics):—

John Andrew Aitken (P.), David Anderson (M.), Donald Arbuckle (P.), Thomas Archibald (M.), William Hunter Stirling Armstrong (M.), James Currie Auchencloss (P., M.), Alexander Ballantyne, M.A. (P.), William Barr (A.), Charles Bennett (A., P., M.), John Blakely (M.), John Lindsay Boyd (M.), Charles Brash (P.), William Barrie Brownlie (M.), David Young Buchanan (A., P., M.), Hector Mackay Calder (M.), John Cameron (M.), Matthew Ignatius Thornton Cassidy (M.), Donald James Clark (A., M.), James Cook (Coalburn) (A., P.), James Cook (Partick) (M.), Walter Dawson (A., M.), Thomas Loudon Fleming (M.), Thomas Scott Forrest (A.), William Leonard Forsyth (M.), John Fotheringham, B.Sc. (M.), William Ernest Gemmell (P.), Alexander Thomas Arthur Gourlay (A., M.), Thomas Edmondstone Gray (A., P., M.), Josiah Stranaghan Harbinson (M.), Michael Harkin (A., P.), Stephen John Henry (A., P., M.), James Hall Hislop (A., P., M.), William Alexander Hislop (A., P., M.), Benjamin Hutchison (M.), Walter Hermann Kiep (M.), Thomas Joseph Kirk (P.), John Lang (M.), Daniel Conway M'Ardle (A.), Angus Macaulay (P., M.), Alexander Macphail Macdonald (A., P.), William M'Kendrick (A.), Francis William Mackichan (P., M.), William Campbell Mackie (A.), Alexander M'Kinnon (P.), John James Mackintosh (A., P., M.), James Walter M'Leod (M.), John MacMillan (M.), Allan M'Pherson (P., M.), Murdo M'Kenzie M'Rae (P., M.), Andrew Maguire A., P.), William Aubrey Layard Marriott (P.), Frank Needham Marsh (A., P., M.), Kenneth Chisholm Middlemiss (M.), Robert Wright Mitchell (A., M.), John Mowat (P.), James Muir (A.), William Aikman Muir (M.), Charles Sutherland M'Kay Murison (M.), Archibald Naismith (M.), Watson Noble (P., M.), David Purdie (A.), Edward Quigley (A., P., M.), Richard Rae (M.), Henry Nimmo Rankin (P., M.), Nicol M'Nicoll Rankin (M.), Hugo Given Robertson (A., M.), Allan Semple (P., M.), James Brown Sim (M.), Alexander Hunter Sinclair (M.), James John Sinclair (P.), Donald Stewart (A.), Edward Ernest Stewart (P.), David Taylor (M.), Walter Telfer (P.), John Shedden Thomson (A., M.), Arthur Turnbull, M.A., (A., P.), Robert Macnair Walker (M.), David M'Gruther Wilson (A.), John Alexander Wilson (A.), William Mitchell Turner Wilson (A., P., M.), John Youngson Wood (P., M.), Hugh Young (A., M.), John Young (A., P.). Women—Margaret Baird Sproul Darroch (M.), Euphemia Adamson Hay (P.), Jessie Deans Rankin (A.), Olive Robertson (A., P.), Jessie Capie Russell (M.), Jeanie Hinshaw Stewart (P.).

The following have passed the third professional examination for the degrees of M.B. and Ch.B. in the subjects indicated (P., Pathology; M., Medical Jurisprudence and Public Health):—

Murdo Buchanan (P., M.), James Cairncross (P.), John Craig Crawford (P.), Neilson Davie (M.), James Cowie Dick (P.), James Dunbar (P.), William Hunter Duncan (P., M.), Allan Dunsmuir (P.), Alexander Wylie Eadie (M.), William Marley Elliott (M.), John Ferguson (M.), Thomas Forsyth (P.), George Muir Fraser, M.A. (P., M.), Samuel Nicol Galbraith (M.), David Gibson (P., M.), John Vincent Grant (P., M.), James Dow Gray (P., M.), David Hamilton (P., M.), Alexander Mills Kennedy (P., M.), Charles Lawson Kerr (P., M.), James Towers Kirkland (M.), George Ligertwood (M.), Alexander Tulloh Inglis Macdonald (M.), James M'Donald (P., M.), Neil MacInnes, M.A. (P., M.), Robert M'Inroy (M.), Joseph Bogue Mackay (P., M.), Thomas Cooper Mackenzie (P.), James Hogg Martin (M.), William Spence Melville (M.), John Clark Middleton, M.A., B.Sc., P., M.), Allan Frederick Miller M.), John Wilson Miller (M.), Thomas Miller (M.), John Oswald (P., M.), Daniel M'Kinley Reid (P., M.), Thomas David Coulthard Ross (P., M.), James Alexander Stenhouse (M.), John Stewart, M.A., B.Sc., (P., M.), John Martin Taylor (M.), David Alexander Thomson, M.A. (P., M.), Hugh Johnstone Thomson (M.), John Archibald Thomson (P., M.), Thomas Macknight Watt (P.), John Weir (P., M.), David John Williams (M.), Garabed Yeghia Yardumian (P.), Matthew Young (P., M.) *Women.*—Margaret Gardner Forrest (P., M.), Ella Smith Hill, M.A. (P., M.), Annie M'Corrie (M.), Janet Annie Macvea (P., M.), Jane Isabel Robertson, M.A. (M.).

The following passed with distinction in the subjects indicated:—

First Examination.—In Botany and Physics.—James Hendry, M.A.; Thomas Jones Mackie, Andrew Bruce MacLean. *In Zoology and Chemistry.*—David Thomas Crichton Frew. *In Physics and Chemistry.*—James Jack. *In Botany.*—James Turner Brown. *In Zoology.*—Samuel Bryson, Jeanie Douglas M'Whirter, Barbara Grace Rutherfurd, Florence Elizabeth Sexton. *In Physics.*—David Rutherford Adams, Hugh Forrest, Andrew Garvie, Nicholas Gebbie, John Gray, Andrew Ross Muir, Daniel Wright Ritchie, Gilbert Innes Strachan, James Douglas Walker, Alexander Stewart Wilson, Henry Yellowlees. *In Chemistry.*—Peter Drummond, William Howat, M.A.; Harold Edward Whittingham.

Second Examination.—In Physiology.—Arthur Turnbull, M.A. *In Materia Medica and Therapeutics.*—John Fotheringham, B.Sc.; Walter Hermann Kiep, Robert Macnair Walker.

Third Examination.—In Pathology and in Medical Jurisprudence and Public Health.—John Clark Middleton, M.A., B.Sc. *In Pathology.*—Matthew Young. *In Medical Jurisprudence and Public Health.*—Alexander Wylie Eadie, Hugh Johnstone Thomson.

University of Durham.

At the Convocation holden on Saturday, September 29, 1906, the following degrees were conferred, viz.:—

Doctor in Medicine.—Lewis A. Clutterbuck, M.B., B.S., Durh.; Sophia B. Jackson, M.B., B.S., Durh.; Philip W. James, M.B., Durh.; Thomas C. Rutherfoord, M.B., B.S., Durh.; William Simpson, M.B., B.S., Durh.; John A. Swindale, M.B., B.S., Durh.

Doctor in Medicine for Practitioners of Fifteen Years' Standing.—Alfred J. G. Barker, M.R.C.S.; Frederick J. Brown, M.R.C.S., L.S.A.; James D. Cree, M.R.C.S., L.R.C.P.; Thomas L. Crooke, L.R.C.P. and S., E.; Edward J. Cross, M.R.C.S., L.R.C.P., D.P.H.; Matthew Dobbs, M.R.C.S., L.R.C.P., L.S.A.; Henry J. Edwards, L.R.C.P. and S., D.P.H.; Edward Ellis, L.R.C.P. and S., E.; Joseph W. Gill, M.R.C.S., L.R.C.P., D.P.H.; Frederick M. Graham, F.R.C.S., L.R.C.P., L.F.P.S.G.; Charles R. M. Green, F.R.C.S., L.S.A., D.P.H.; Hubert Joslen, M.R.C.S., L.R.C.P.; Arthur B. Kingsford, M.R.C.S., L.R.C.P., D.P.H.; Robert E. Lauder, F.R.C.S., E., L.R.C.P., D.P.H.; James Menzies, L.R.C.P. and S., E., L.F.P.S.G.; Charles J. Sharp, M.R.C.S., L.R.C.P.; Arthur G. Southcombe, M.R.C.S., L.R.C.P., D.P.H.; George G. Stuart, L.R.C.P. and S., E., L.F.P.S.G.

Master in Surgery.—Thomas Y. Simpson, M.D., B.S., Durh., M.R.C.S.

Bachelor in Medicine (M.B.).—Vincent E. Badcock, George E. Denholm, Reginald I. Douglas, M.R.C.S., L.R.CP.; Neville A. Eddlestone, Florence B. Lambert, Arthur C. H. McCullagh, Ernest Martin, L.R.C.P. and S., E., L.F.P.S., G.; Bertha M. Mules, Jessie J. M. Morton, Sidney Nix, L.R.C.P. and S., E., L.F.P.S., G.; Frederick C. Pybus, George R. Philipson, Donald M. Ross, Thomas L. Wormald.

Bachelor in Surgery (B.S.).—Vincent E. Badcock, George Denholm, Reginald I. Douglas, M.R.C.S., L.R.C.P.; Neville A. Eddlestone, Florence B. Lambert, Arthur C. H. McCullagh, Ernest Martin, L.R.C.P. and S., E., L.F.P.S., G.; Bertha M. Mules, Jessie J. M. Morton, Sidney Nix, L.R.C.P. and S., E., L.F.P.S., G.; Frederick C. Pybus, George R. Philipson, Donald M. Ross, Thomas L. Wormald.

Bachelor in Hygiene (B.Hy.).—Isaac Thompson, M.B., Ch.B., New Zealand.

And the following received the *Diploma in Public Health.*—Isaac Thompson, M.B., Ch.B., New Zealand; John Henry Tripe, M.R.C.S., L.R.C.P.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS. ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT SURGICAL LITERATURE.

Case of Anastomosis between the Femoral Veins.—McGregor (*Glasgow Medical Journal*) reports the following case:—W. S., æt. 26, suffered from enteric fever seven years ago, when his left leg became painful and swollen. Three years later he got a second attack of enteric fever, shortly after which he noticed swollen veins on his abdomen. These veins increased in size for some time, and then became stationary. The patient came for treatment, as he feared they might burst. Inspection of the abdomen revealed a plexus of veins occupying the lower segment of the abdominal wall. This was triangular in shape with the apex situated at the umbilicus. The main trunks of this plexus were the superficial epigastrics and superficial external pudics of both sides. They were much altered in shape, being distended and somewhat tortuous. At the left inferior angle of the triangle there was a bulbous swelling, apparently the extreme upper end of the internal saphenous vein. One branch from this was directed horizontally across the pubis, becoming directly continuous with a similar vein on the opposite side. Another branch extended upwards and inwards towards the umbilicus. There was a similar arrangement of veins on the right side. The left internal saphenous vein was not visible in the thigh. The left leg below the knee was somewhat cyanosed as compared with the right. Otherwise the veins of the leg appeared normal. The left calf measured 1¼ inches more than the right. On testing the flow of blood in the dilated abdominal veins, it was noticed that the left side the blood flows from the saphenous opening across the pubis to the right. The left superficial epigastric vein flowed upwards towards the umbilicus, where it anastomosed with its fellow on the right, in which the blood flowed normally—*i.e.*, downwards. When the patient lay supine this plexus of veins was empty; when turned on his right side they remained so; but if turned on his left side they gradually filled. In this case, therefore, the obstruction must have been below the level of the junction of the iliac veins, since the right took up the work of the left. The question arose as to whether these dilated veins might be safely ligatured, and the less exposed deeper branches of the iliac vein trusted to take up the circulation. To ascertain this fact an inguinal truss was employed in such a way that the anastomosing veins would be compressed, and the potency of the normal channels thus tested. Though the patient was allowed to walk about all day, there was practically no difference between the measurement of the affected calf in the morning and the evening. The superficial pudic veins were ligatured on the 30th January, 1905, and the two superficial epigastric veins and their intercommunicating branches six months later. The patient has been at work continuously since the second operation, and no superficial veins are now prominent or visible on the abdomen. S.

Some Surgical Cases.—Major Gabbett, I.M.S. (*Indian Medical Gazette*, September, 1906) reports the following cases:—*Case I.*: Recurrence of stone four years after suprapubic extraction.—A boy of seven was admitted with stone in the bladder. Four years previously a stone had been removed by suprapubic route. The same route for operation was adopted on this occasion, and the bladder found fixed to the abdominal wall by scar tissue. This condition added no serious difficulty in the second operation, which was entirely successful, an oval stone about one inch in its longest diameter being removed. *Case II.*: Intraperitoneal Rupture of the Bladder.—A young, healthy native woman was seen in the out-patients' department complaining of pain and swelling of the abdomen following a kick two days previously. Examination revealed the presence of free fluid in the peritoneal cavity. The symptoms of hæmorrhage or well-established peritonitis were absent. Since the receipt of the injury no urine had been passed. On catheterisation five pints of blood-stained urine were drawn off, evidently from the peritoneal cavity. The patient was immediately removed to the operation table, and an incision revealed a ragged vertical rupture on the posterior surface of the bladder, reaching almost from top to bottom. Considerable difficulty was found in passing Lambert's sutures, so as to close the lower angle of the wound. Only one layer of catgut sutures was used. The bladder was now proved water-tight, and an indiarubber tube was passed down behind the sutures. An attempt was made to keep a catheter in the bladder, but as it was constantly removed by the patient the attempt was given up. On the third day there was a suspicion of urine sucked up from the tube by a syringe, and on the fourth no doubt existed that leakage had occurred. On re-opening the abdomen the greater part of the line of sutures was found to have given way, probably from absorption or slipping of the catgut. The edges of the tear were ragged, swollen, and so friable that resuturing was out of the question. The coils of the gut in the pelvis were sticky with commencing formation of lymph, and slightly adherent to each other. As a last resource four silkworm gut sutures were passed through the whole thickness of the bladder at some distance from the edges of the rent, one on either side of the lower angle, and one on either side of the upper angle. They were then drawn up in a purse-string manner, and fastened to the abdominal wall. A rubber tube was passed through the mouth of the so-formed purse into the bladder. The pelvis was then mopped with dry sponges, and the abdominal wall sutured as after a suprapubic extraction of stone. The sinus was healed six weeks afterwards, and the patient discharged as cured. S.

The Results from the Bloodless Reduction of Congenital Hip Dislocation.—Stern (*Medical Record*, 15th September, 1906), reports the results he obtained in fifteen individual hips operated on by the bloodless method. There were twelve patients treated. Failure in reduction occurred in three old-standing and well-developed cases. All refused a second trial, or a trial of Schlesinger's method. There was one total failure due to poor judgment in operating upon an unsuitable case. Six anatomical cures resulted, one ideal functional result, three transpositions with good function. One patient is still under treatment. By anatomical restitution is meant cases where the limbs are of equal length, the lordosis and waddling gait gone, the joint freely movable, the head of the femur entirely within the acetabulum, both to palpation and to X-rays, and where clinically such a hip does not differ at all from a normal joint. A perfect functional result means practically the same thing, only that clinical examination or X-rays reveal some gross anatomical abnormality. Posterior redislocation and relapses cannot be avoided. Many may be due to faulty technique, but most are due to some natural anatomical obstruction, shallow acetabulum, large head, excessive ligamentum teres, etc. These cases should be repeatedly subject to bloodless reduction, and where this finally fails the bloody operation should be done. Unsuccessful operations are due to two causes, the most important thing being the advanced age or excessive muscular development of the patient. Four to six years in bilateral cases and seven to ten in unilateral cases should be the upper age limits. Where the malformation of the parts is the chief obstruction to successful reduction, as, for instance, an hour-glass constriction of the capsule, arthrotomy as advocated by Bradford allows of perfect

exploration and removal of obstruction. The constant tendency for a reduced joint to redislocate may be overcome by the use of Werndorff's axillary abduction for a number of weeks, followed by ordinary primary position. Untoward results such as paralysis, fractures, gangrene, etc., cannot always be avoided, but are vastly less common than they were before the year 1900, when the use of traction instruments was entirely given up by the best operators. The author has compiled statistics of all hips which have been reported as successfully operated on during the last five years. Looking at the results from a functional standpoint alone, out of the total 2,593 cases, in 2,307, or 88.96 per cent., good functional joints have been obtained. S.

The Development of Lamellar Cataract.— H. B. Grimsdale (*The Ophthalmoscope*, August, 1905) has had the opportunity of watching the development of Lamellar Cataract in a boy aged 3, well-developed and healthy, with no signs of rickets. Beyond a "fit" at 12 months he had had none of the ordinary diseases of childhood. The child's sight had been noticed to be defective for some months, and was getting worse. Under atropine a "good reflex" was noted, but no details of the fundus could be made out. Although no separate opacities could be seen in the lens, Grimsdale had no doubt as to the cause of the bad vision, so he removed the lens by several needlings, after which he could see the fundus details. Before the boy left hospital the other lens showed definite opacities. After two years the boy returned, and then had a typical lamellar cataract in the eye which had not been treated. It would appear that the cataracts in this case were not congenital, as the parents were precise as to the onset of the bad vision. On account of the absence of nystagmus it was concluded that the sight must have been fairly good. M.

Myasthenia Gravis.—Taylor and Lawford (*Trans. Ophthal. Society*, Vol. XXIV.) record a case each. Taylor's case was that of a painter, æt. 46, who had suffered from colic and painter's gout. No history of paralysis. Ten years ago had ptosis, and during following six years had it intermittently. Nine years ago had diplopia, which became permanent for past four years. Weakness of lower limbs, arms, and hands. He could not read for long at a time. There was paralysis of ocular movements, pupils reacted to light, arm and leg movements easily exhausted, difficult mastication, but speech good. Myasthenic reaction in affected muscles. Reflexes and sphincters normal. Lawford's patient was a baker, æt. 51, and had good health up to 14 years ago, when he had influenza, after which lids commenced to droop, and got gradually worse. General weakness came on until Christmas, 1903, when he had to give up work. All the eye muscles were very weak, marked ptosis, pupils equal and active, media clear, normal fundi, visual acuity $^{6}/_{12}$. From the detailed history of the case, we gathered the following:—Temporal and masseter muscles weak, tongue protruded straight, but side motion is very weak; muscles supplied by seventh pair show loss of tone; is unable to whistle loudly, elevation of the soft palate is defective, fluids regurgitate through nose, and there is a nasal intonation; weak abduction of the vocal cords, walks slowly and is easily tired, flabbiness and weakness of muscles of arms, legs, abdomen, and back. Conjunctival reflex was dull. Palate and knee reflexes present; sphincters normal. The patient wore with comfort a pair of spectacles with wire lid-crutches fitted, which held up his lids and saved him having to throw back his head to see better, an action which he was unable to maintain for long. M.

Urinary Calculus and its Detection with the X-rays.—E. W. Shenton (*Lancet*, September 15), draws attention to the very general misconception with regard to the proper use of the X-rays in the detection of urinary calculus. It is now recognised that there are two methods in which the rays may be used—first, for screen examination, and secondly, for photographic effects; and beyond question the former is the more serviceable in diagnosing lithiasis. A difficulty frequently put in the way of the radiographer by the surgeon is the request for a skiogram of large dimensions, including both ribs, kidneys, and iliac crests. In a photograph so large as this, only the most opaque and obtrusive stones will show at all. The author then describes in detail his method of conducting screen examinations in cases of suspected stone in the kidney, and states that, in a long series of cases in which he has been able to check the accuracy of his reports, none have proved incorrect since this method of screen examination has been in use. G.

Hand Disinfect —H. J. Boldt (*The Post Graduate*, July, 1906), discusses this important subject. The ideal condition is absolute sterilisation; this, however, has not yet been obtained. The three methods most commonly used are—Fuerbringer's, by means of hot water, alcohol, and mercury bichloride; Kelly's method, requiring potassium permanganate and oxalic acid; and third, the use of chloride of lime and soda. These are all imperfect. The disinfecting power of formaldehyde is well known; unfortunately it is very irritating. Recently, however, a solution of pure formaldehyde in soap has been obtained. This demethylated saponified formaldehyde, free from formic acid, is unirritating, and is called "Veroform antiseptic." The soap being free from formic acid, and neutral, enables it to be used on the most sensitive and delicate tissues of the human body without causing harm. The results obtained by Dr. Boldt with this antiseptic have been excellent. The following technique is reliable. First, each hand, with the finger-nails cut short, should be scrubbed for five minutes with a good soft soap and hot water, which should be repeatedly changed, then each hand should be scrubbed for from three to five minutes with a solution containing two to four fluid drams of Veroform antiseptic to a pint of water, after which the hands, as desired, may or may not be rinsed in sterile water. It does not roughen the hands or harden the skin. In this and in other respects it is more agreeable than the disinfectants now in use. G.

Cholecystotomy: An Improved Technique. —Hugh Crouse (*New York Medical Journal*, September 22, 1906), suggests an improved technique for the operation of Cholecystotomy. The three methods suggested by Mayo Robson are all faulty. They are cuffing back the transversalis fascia and peritoneum, attaching these to the unopened gall-bladder, and forming by this means a fascial canal. The gall-bladder is opened through this 48 hours later. In this method the delay of 48 hours is often too long, and the difficulty in recognising the fundus of the gall-bladder at the end of this time is often extreme. In the second method the right border of the omentum is sutured to the gall-bladder and the peritoneum, and immediately incised, in this way forming an omental wall to the tube draining the gall-bladder. This method has the objection that the canal is insecure, and the danger of fat necrosis occurring in the omentum is great. The third method is that of a purse-string suture retaining the tube in the fundus of the gall-bladder, and packing round this with gauze and making a secondary gauze drain through the renal hepatic fossa. This method leaves the probability that when the tube is removed an unadherent space may remain between the gall-bladder and the abdominal wall, thus allowing the still open bladder to drain into the free abdominal cavity. The author's method of dealing with such cases of contracted gall-bladders which require drainage is as follows: the gall-bladder is dissected off from the under surface of the liver; this allows it to be brought right out through the abdominal wall. A piece of perforated rubber sheeting is then passed over the gall-bladder and carried as far down along its duct as possible. The gall-bladder can then be opened and thoroughly washed out without any danger of soiling the peritoneum. The fundus of the gall-bladder is then stitched up to the abdominal wall. This operation has proved successful in the author's hands, and avoids the dangers and disadvantages of the other methods commonly employed at the present time. G

NOTICES TO CORRESPONDENTS, &c.

☞ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to 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 proofs.

SUBSCRIPTIONS.

SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance.

KAPPA.—The Spa you mention can be reached in 19 hours from London and 10 from Paris. It stands at over 1,000 metres.

RAY.—Actinomycosis of the intestines is not very uncommon. The rectum and cæcum are the parts most affected. In 111 cases collected, in 62 the cæcum and appendix were the probable seats of the disease. The process generally terminates in intestinal fistula.

THE FIRE AT MESSRS. ALLEN AND HANBURY'S.

MESSRS. ALLEN AND HANBURY ask the hospitality of our columns to inform the profession that the general conduct of their business is in no way interfered with. The fire was confined to two large buildings used respectively for the bottling of oils and the manufacture of hospital furniture. Their warehouses, laboratories, offices, and printing department are in no way affected, and there is consequently no interruption whatever of business. Accommodation for the two crippled departments has been already provided in their own premises at Bethnal Green and at the West End.

TERMINOLOGICAL INEXACTITUDE IN MEDICINE.

THE subject of medical terminology was discussed in a lecture on Saturday by Dr. Clifford Allbutt, on "Men and Things," delivered before the Guy's Hospital Physical Society. Sir Samuel Wilks, who presided, referred to an amusing case which he had recently seen reported in a medical journal. A medical man had thought that he had before him a case of appendicitis, but found on operating that it was nothing of the kind. Instead, however, of saying that he had made a mistake, he called the case "pseudo-appendicitis."

FERMENT.—Glycogen is converted into starch by many agencies; acids, diastase, and ferments in the pancreas, liver, saliva, and blood all have this action, more or less.

S. L.—The cause of the disappearance of yellow fever in cold weather is, doubtless, the disappearance of the mosquito.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, OCTOBER 17th.

POST-GRADUATE COLLEGE (West London Hospital).—10 a.m.: Diseases of the Throat, Nose, and Ear. Diseases of Children. 2 p.m.: Medical and Surgical Clinics. 2.30 p.m.: X-Rays. Operations. 5 p.m.: Lecture:—Unusual Cases of Appendicitis.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. L. Mummery: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. J. S. Collier: The Pathology and Treatment of Cerebral Vascular Lesions.

LONDON SCHOOL OF CLINICAL MEDICINE (Dreadnought Hospital, Greenwich).—2.30 p.m.: Operations. 2.30 p.m.: Dr. R. Wells:—Medicine. 3.15 p.m. Mr. M. Robson:—Surgery. 4 p.m.: Mr. Carglil:—Ophthalmology. Out-patients Demonstrations:—10 a.m.: Surgical and Medical. 11 a.m.: Eye.

CENTRAL LONDON THROAT AND EAR HOSPITAL (Gray's Inn Road, W.C.)—5 p.m.: Demonstration:—Dr. D. Grant: Case Taking.

THURSDAY, OCTOBER 18th.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street, Cavendish Square, W.).—8 p.m.: Card Specimens. 8.30 p.m.: Papers:—Mr. H. Spicer: Intraocular Infections. Mr. G. Coats: Posterior Scleritis. Dr. Edridge-Green: Observations on Hue Perception.

MOUNT VERNON HOSPITAL (7 Fitzroy Square, W.).—5 p.m.: Dr. J. E. Squire:—"Bronchiectasis."

POST-GRADUATE COLLEGE (West London Hospital).—2 p.m.: Medical and Surgical Clinics. 2.30 p.m.: X-Rays. Operations. Diseases of the Eye. 5 p.m.: Lecture:—Anæsthetics.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC.—4 p.m.: Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m.: Lecture:—Mr. M. Morris: The Treatment of Some Common Skin Affections.

LONDON SCHOOL OF CLINICAL MEDICINE (Dreadnought Hospital, Greenwich).—2.30 p.m.: Operations. 2.30 p.m.: Dr. G. Rankin: Medicine. 3.15 p.m.: Sir W. Bennett: Surgery. 4 p.m.: Mr. M. Davidson: Radiography. Out-patient Demonstrations:—10 a.m.: Surgical and Medical. 12 noon: Ear and Throat.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—5 p.m.: Chesterfield Lecture:—Dr. M. Dockrell: Eczema, its Varieties, Symptoms, and Causes.

FRIDAY, OCTOBER 19th.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.—5 p.m.: Clinical Cases. Papers.

POST-GRADUATE COLLEGE (West London Hospital).—2 p.m.: Medical and Surgical Clinics. Diseases of the Throat, Nose, and Ear. 2.30 p.m.: X-Rays. Operations. Diseases of the Skin. 5 p.m. Lecture:—Surgical Cases.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC.—4 p.m. Mr. S. Stephenson: Clinique. (Eye.)

LONDON SCHOOL OF CLINICAL MEDICINE (Dreadnought Hospital, Greenwich).—2.30 p.m.: Operations. 2.30 p.m.: Dr. R. Radford:—Medicine. 3.15 p.m.: Mr. McGavin:—Surgery. Out-patient Demonstrations. 10 a.m.: Surgical and Medical. 12 noon: Skin.

Vacancies.

Somerset Hospital, Cape Town.—Assistant Resident Medical Officer. Salary £200 per annum, with quarters and rations. Applications to David and Soper, Agents of the Somerset Hospital, Cape Town, 54 St. Mary Axe, London, E.C.

West Suffolk General Hospital, Bury St. Edmunds.—House Surgeon. Salary £100 per annum, with board, residence, and washing. Applications to John H. Bonner, Secretary.

Cornwall County Asylum, Bodmin.—Second Assistant Medical Officer. Salary £150 per annum, with board, furnished apartments, washing, &c. Applications to the Medical Superintendent.

Durham County Hospital.—House Surgeon. Salary £120, with board and lodging. Applications to Wm. R. Wilson, Secretary, 68½, Saddler Street, Durham.

Saint Leonard, Shoreditch.—Second Assistant Medical Officer. Salary £100 per annum, with rations, washing, and furnished apartments. Applications to Robert Clay, Clerk to the Guardians, Clerk's Office, 213, Kingsland Road, N.E.

Bradford Royal Infirmary.—House Physician. Salary £100 per annum, with board and residence. Applications to Edmund Forster, Secretary.

Bradford Royal Hospital.—House Surgeon. Salary £100 per annum, with board and residence. Applications to Edmund Forster, Secretary.

Appointments.

BROWN, A. CARNARVON, M.R.C.S., L.R.C.P.Lond., Senior House Physician at the Great Northern Central Hospital, Holloway Road, N.

BROWN, ROBERT, M.B., Ch.B., Junior House Surgeon at the Great Northern Central Hospital, Holloway Road, N.

CLARK, JAMES, M.B., Ch.B., Senior House Surgeon at the Great Northern Central Hospital, Holloway Road, N.

GUNN, RODERICK M., M.B., Ch.B., B.S., Junior House Physician at the Great Northern Central Hospital, Holloway Road, N.

HARGEST, JOHN FREDERIC, M.B., C.M.Edin., District Medical Officer by the Bristol Board of Guardians.

HOLDEN, ARTHUR S., M.B., Ch.B.Edin., Assistant Resident Medical Officer at the Sheffield Union Hospital.

LONGWILL, DAVID, M.B., Ch.B.Glasg., Medical Officer of Health for Shettleston District by the Glasgow Parish Council.

LYON, GEORGE, M.B., Ch.B., F.R.C.S.Edin., Pathologist to the Great Northern Central Hospital, Holloway Road, N.

JAMES, W. T., M.B., B.S.Edin., Certifying Surgeon under the Factory and Workshop Act for the New Quay District of the county of Cardigan.

MACKENZIE, T. C., M.B., M.R.C.P.Edin., Senior Assistant Physician at the Royal Asylum, Aberdeen.

MANSON, J. S., M.B., Ch.B.Edin., Senior House Surgeon at the Oldham Infirmary.

PICKETT, JACOB, M.D.St. And., M.R.C.S., Consulting Surgeon to the Metropolitan Ear, Nose, and Throat Hospital.

PRICE, DAVID THOMAS, M.B.Lond., Medical Officer by the Shepton Mallett (Somerset) Board of Guardians.

RHIND, THOMAS, L.R.C.P.Lond., M.R.C.S., D.P.H.Camb., Medical Officer and Public Vaccinator to the Hawkesbury District by the Chipping Sodbury (Gloucestershire) Board of Guardians.

RUTHERFORD, JOHN V. W., M.B., M.S.Edin., Honorary Surgeon to the Royal Infirmary, Newcastle-on-Tyne.

SMITH, HOYLAND, M.R.C.S.Eng., L.R.C.P.Lond., Senior Resident Medical Officer at the Sheffield Union Hospital.

Births.

EVERINGTON.—On Oct. 11th, at Cumnor, Sanderstead, the wife of H. D. Everington, M.B., M.R.C.S., of a daughter.

MYERS.—On Oct. 12th, at the residence of her parents, the wife of Charles S. Myers, M.A., M.D., Cambridge, of a son.

ORMEROD.—On Oct. 7th, at Beauchamp Lodge, Wimborne, the wife of Ernest W. Ormerod, M.D., of a son.

VIZARD.—On Sept. 28th, at Ireland Island, Bermuda, the wife of Staff-Surgeon A. H. H. Vizard, M.D., Royal Navy, of a daughter.

Marriages.

BILLSON—MOORE.—On Oct. 10th, at the Parish Church, Chalsey Berks, Charles Billson, L.R.C.P., M.R.C.S., of Hornsey, to Dora Emily, only daughter of the late Thomas Moore, of Burton-on-Trent.

WANKLYN—RAWSON.—On Oct. 11th, at St. Mary's, Carlow, William Lumb, youngest son of the late Frederic Wanklyn, of Buenos Aires, to Marjorie Josephine, youngest daughter of Edward S. Rawson, M.D., of Barrowville, Carlow.

WILLETT—CATT.—On Oct. 10th, at Duffield Parish Church, Alfred Stuart Willett, of Bolney, Sussex, third son of Alfred Willett, F.R.C.S., to Cicely Hilda, third daughter of Mr. and Mrs. C. W. Catt, of The Outwoods, Duffield.

Deaths.

COX.—On Oct. 8th, at Theale, Reading, Berks, Robert David, youngest son of the late Richard Cox, M.D.

WILLS.—On Oct. 12th, at Lunecliffe, Lancaster, Lieut.-Colonel Caleb Shera Wills, C.B., R.A.M.C. (retired), aged 72.

WIMBLE.—On Oct. 13th, at 29 South Avenue, Rochester, Florence, youngest daughter of the late Frederick Wimble, M.R.C.S.E., of East Malling, Kent.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIII. WEDNESDAY, OCTOBER 24, 1906. No. 17.

NOTES AND COMMENTS.

A Domestic Sarsaparilla Factory.

A FEW days ago a widow was charged at Stratford Police Court with neglecting her four children. A relieving officer stated that he had never seen a dirtier woman or a place in such a deplorable condition. She had come to him at night the worse for drink, and on one occasion he found the children quite naked. A medical man testified that one child suffered from rickets and scalp eczema, while all of them were verminous and indescribably dirty. Yet the occupation carried on by the woman in this hovel was the making of sarsaparilla wine. Clearly the moral of this sordid story applies to other places than Stratford. The bare fact that such an incident is possible in our present stage of hygienic civilisation may well make us look into public health matters a little more closely. Needless to say, the purity of our food and drink supplies is of vital importance to the well-being of the community. It is no less clear that a high standard in these first necessities can never be secured without adequate powers and unceasing vigilance. Hence the desirability of insisting upon the official control of all places where articles of food or drink are prepared. This matter, it is to be hoped, will engage the serious attention of Parliament at an early date. Meanwhile there will doubtless be a "slump" in the sarsaparilla trade.

The Prevention of Consumption.

THE County Council of the West Riding of Yorkshire have taken the consumption question vigorously in hand. They have drawn up an elaborate table of means for combating and preventing the malady, and have asked every authority within their area to help in their enforcement. As a matter of fact, their attack is to be made all along the line—the only way in which tuberculosis will ever be stamped out. The old truism that a chain is no stronger than its weakest link applies emphatically to the prevention of this terrible and insidious foe of mankind. To notify and isolate cases is useless without disinfection and general education of the public. Above all, it is simple folly to spend money in costly sanatoria, and to cure a few of the better-to-do classes, while the bulk of the poor patients remain practically untouched. The ordinary out-patient treatment of consumptives is a snare and a delusion. Lastly, all our measures are futile unless we insist upon a rigorous control of farms, dairies, and meat supply.

Free Midwifery.

AT a recent inquest the City of London Coroner called attention to a case in which a woman was attended in her confinement by a medical student from Guy's Hospital. It came out in evidence that the husband earned from £2 to £3 a week, and the foreman of the jury naturally asked why a registered medical man had not been called in. The probable explanation is that the gentleman in question was human enough to prefer getting his medical attendance for nothing. A medical man from the hospital stated that enquiries were made into the means of all applicants for medical assistance, and the father stated that he had earned nothing for nine weeks owing to "ill-luck." In this particular instance, the Coroner agreed that the parents were not in a position to pay medical fees. It is well to draw attention to the maternity practice of medical schools, as its abuse in some cases constitutes a great hardship to outside practitioners. Other coroners please copy.

The Man of Many Woes.

TRULY the plight of the general practitioners is woeful. An enormous stream of poor patients is diverted from their doors to those of the medical charities. Midwifery cases are catered for by maternity charities, by hospitals, and by midwives. Bogus practitioners of all kinds attend thousands of patients suffering from cancer, consumption, nervous diseases, dislocations, rheumatism, and what not. Another vast section of the public are swindled by the quack medicine vendors. Were these and various other pernicious forms of competition brought under control, the field for medical men would be enormously multiplied, and the safety of the community proportionately increased. Public opinion shows some signs of awakening, so also does the general practitioner. But he has already spent far too much time in the preliminary yawns and stretchings. When will he really shake off this most pernicious and drowsy slothfulness and gird up his loins for action?

LEADING ARTICLE.

PLAGUE EXPERIMENTS IN INDIA.

THE enormous and shocking mortality from plague in India is a standing reproach to the sanitary administration of that empire. This mortality has been steadily increasing year after year, and has now reached the stupendous figure of one million yearly. Though asserting that such figures throw discredit on the administration, we do not mean that the Indian Government have been totally inactive, but rather that, when the disease failed to respond to their efforts in the first instance, instead of redoubling their vigour and increasing their determination, they adopted the attitude of their Oriental subjects and murmured "Kismet." In the MEDICAL PRESS AND CIRCULAR it was urged that, administrative measures having failed, although applied with vigour and in the full light of present-day knowledge, the plain duty of the Indian Government was to appoint a *cadre* of highly expert scientific investigators to examine plague in every phase, clinical, pathological, and epidemiological, till it was discovered how the disease spread, and consequently how to proceed in preventing it. True, a Commission was appointed, but its report was lame and disappointing, and though the German Commission carried matters a stage further, the point was never reached at which science could give a clear guide to the Health Department as to how to direct its energies. Thanks, however, to the initiative of the Lister Institute, Mr. Brodrick early last year issued directions for a further inquiry and placed a grant at the disposal of the Royal Society and the Lister Institute for the purpose. A fairly strong Commission was appointed, and already, within eighteen months of getting to work, it has accomplished sufficient to demonstrate that a few hundreds a year spent in experiment and thought are worth as many millions spent in blind administrative action. Although it is far too early for the Commission yet to report, it has published in the *Journal of Hygiene* a number of separate papers detailing the researches of various members of the Commission and their assistants, and these papers are not only of intense scientific interest, but they shed a new and lurid light on the epizoological characteristics of plague. It may be well to recall the facts that, though the Bacillus pestis was shown by Kitasato to be the organism of plague, and though rats were known to suffer from the disease, the method of transmission of plague from rat to man was unknown. It was recognised that when rats began to die of plague in a house that house became an infected house, and that it was difficult in the extreme, even after all the rats were dead, to disinfect it satisfactorily. Everything about the house was suspect, and the floor was the part generally fastened upon as the nursery of the bacillus, principally because it was contaminated with the excretions of rats, and its filthy condition pointed to it as an ideal nidus for infection. The other chief theory in the field was that fleas acted as intermediaries for the transmission of plague between rat and man. From time to time B. pestis had been shown to exist in the stomach of fleas living on infected rats, and it was believed even to multiply in that situation, but attempts actually to transmit infection by the bites of infected fleas were generally unsuccessful, and there remained the awkward fact—or what was believed to be the fact—that the rat-flea did not bite man. Moreover, if it did attack man occasionally, there was another hiatus when the passage of plague from man to man came to be considered. Captain Liston had done something to clear the ground on these points before the Commission arrived, but the whole subject was in an unsatisfactory and chaotic condition.

It would take us far beyond the bounds of reasonable space even to summarise here the details of the ingeniously-contrived and carefully carried out experiments of the workers on the Commission, but their chief findings we may mention, as they are pregnant with significance for the future, not only of plague, also of other infectious diseases. In the first place, they have shown conclusively that plague can be transmitted from infected rat to uninfected rat solely through the influence of fleas, and that, contrary to generally accepted ideas, the rat-flea not only does bite man, but that in plague-infected houses a considerable portion of the fleas that infest man are rat-fleas (*Pulex cheopis*). Then, by experiment, it was demonstrated that healthy animals, placed in contact with infected ones, do not contract plague if no fleas are present, even a plague-stricken female being able to suckle her young without infecting them. If, however, fleas are introduced, the uninfected animals are rapidly infected, and even if the infected animals are removed and uninfected ones placed in the cage with the fleas, they generally contract plague. Infection from the soil and infection from the air have been disproved, and the transmission of plague by means of fleas from rats to other animals such as guinea-pigs and monkeys have been shown to occur. Further trials were made to find whether the infection in plague-stricken houses resided in the floor, the air, or the flea, and the flea proved itself again to be the agent at fault, even when the houses had been "disinfected" in the usual manner. In a word, the case against the flea as the intermediate host of plague is now as clear as the case against the mosquito in malaria and yellow fever, and the energies of the sanitary department of the Government of India will probably be directed into fresh and more promising channels.

NOTES ON CURRENT TOPICS.

The Sight-testing Opticians.

AN interesting, if not amusing, position has been attained in respect to the question of the sight-testing opticians. It will be remembered that the Spectacle Makers' Company promoted a Bill last summer in the House of Lords by which powers were sought to be obtained for legalising the position of opticians as qualified to test the sight. This Bill has now been abandoned, inasmuch as the Spectacle Makers' Company have found that, according to their charter, granted by Charles I., all the members of the company must be connected with the profession (?) of spectacle-making, and must possess a practical knowledge of the art. The fact of the matter, however, is that not one of the promoters of the Bill is connected with the trade. For example, one is a

newspaper proprietor, another a banker, while others are: a public caterer, a fancy goods warehouseman, an educationalist, a shipowner, and engaged in various pursuits in the City. Under these circumstances the Spectacle Makers' Company became afraid to submit their qualifications, as spectacle-makers, to the test of Parliamentary inquiry, and hence the withdrawal of their Bill. Now comes the amusing part of the contre-temps. The optician members of the Company, not to be debarred from their sight-testing propensities, have agreed among themselves to bring a Bill before Parliament, independently of the powers that be, with the object, among other things, of enforcing the conditions of the charter—that is to say, as members of the Spectacle Makers' Company, they have determined that they will be ruled only by members of the Company who are *bona-fide* spectacle-makers. What a storm in a teacup this attitude is likely to prove to the public! Nevertheless, to what will it lead should the opticians prove that they alone, and not the bankers, toy-makers, caterers, and so forth, by whom the Company is at present governed, are entitled to be members of the Company? The position, we say again, is both interesting and amusing.

Skin for Tobacco.

The skin of the modern newspaper man, as regards things medical, is as impervious as that of the rhinoceros; nothing seems capable of puncturing it. Every six months or so he deals out some old fact, dressed up in topical guise, with an ingenuousness as refreshing as it is rare in these days of British Encyclopædias and universal knowledge-guides. Flesh-grafting, one would have thought, was as much a piece of stock knowledge as the fall of the autumn leaf; but on the newspaper man's skin the grafts have not yet taken. A rare and noble sacrifice, he tells us, was made by two paupers at Stoke-on-Trent last week, when they allowed skin to be cut from their arms to supply a deficiency in the leg of a companion. But as the Guardians voted the two heroes three months' supply of tobacco free in recognition of their brave act, we fancy they will be eagerly on the look-out to sacrifice themselves again when that period is drawing to a close. But the Stoke-on-Trent paupers are not in it with Dr. Lamar K. Tuttle, of 220, West Fifty-ninth Street, New York. The *Daily Mail* thought it worth its while to have telegraphed from America a half-column of "news" which would really be hard to beat. It is headed "Life for Life: Doctor's Heroic Cure of His Mother: Mutilated to Save Her from Disfigurement." "In return for the life his mother gave him," it runs, "the pain and suffering she bore for his sake, and all her loving self-sacrifice," this doctor "has repaid life with life, suffering with suffering, self-sacrifice with self-sacrifice." The lady in question had a severe accident, and, among other injuries, sustained some laceration of the face. In order to save her from disfigurement the son "insisted on his colleagues removing enough of his own skin to cover his mother's lacerated face and arm." One by one, forty pieces of skin were cut from his body and grafted on his mother's healing flesh "The mother," we further learn, "does not know yet the extent of her boy's self-sacrifice."

Winsley Sanatorium.

Occasion was recently taken in these columns to remark on the unfortunate state of the finances of the Winsley Sanatorium. Our comments were made in no spirit of hostility to that institution, which we have reason to believe is admirably conducted and managed; indeed, the committee and medical officers have shown much self-sacrifice and devotion in the promotion of its work. Rather we wished to point out in the first place the desirability, in laying a sanatorium scheme before the public, of not encouraging too sanguine hopes of what a sanatorium can accomplish; and, secondly, of carefully providing financially for all the requirements of such an institution before embarking on building. This particular sanatorium had the unhappy, but not very uncommon, experience of finding that the actual expenditure on its erection and upkeep considerably exceeded the estimate originally presented to the committee; but one knows that architects and builders have a way of presenting things in a rosy light at the outset, and that it is well to provide a margin for unexpected difficulties. The Winsley committee is finding, now that their sanatorium is in full working order, the support it deserves is not forthcoming; and it was recently hinted at a meeting in the neighbourhood that there were certain people who would not be sorry to see it bankrupt, in order that it might be bought cheaply by the town of Bristol. We sincerely trust that nothing so mean is intended, but that that great city will support Winsley as it deserves.

Public Mortuaries.

In some quarters, more especially in the Metropolis, a good deal has been heard in late years of the scientific value of properly conducted public *post-mortem* examinations. It is fairly obvious that a vast mine of pathological and medico-legal material lies comparatively unworked in this direction. A little consideration, however, will show that a similar remark applies more or less aptly to a great number of voluntary and Poor Law infirmaries, schools, barracks, and other huge congregations of individuals. From the peculiar circumstance of the case, it is open to doubt whether the scientific aspects of the Coroner's pathological examinations could ever be systematically utilised. His particular court is concerned in the rapid and businesslike investigation of the causes of death, and there is little time to throw away on side issues. It has been freely alleged against general practitioners that their *post-mortem* examinations are unskilled, hasty, and perfunctory. In a vast number of instances they on their side may point to a wretchedly equipped mortuary or to the absolute lack of any such place, so that the *post-mortem* has often to be conducted under degrading and dangerous conditions. It would be more to the point if coroners throughout the United Kingdom were to insist upon the provision of proper mortuaries as an elementary step

in the direction of satisfactory investigation. That obvious step would raise them in the eyes of the profession far more than the attempt to thrust so-called "experts" into a monopoly at the expense of a poor but honourable profession.

A Surgical Millennium.

MODERN Surgery has taken so many ailments out of the hands of the physician that Mr. H. G. Wells might quite reasonably base his next essay on the Millennium of universal surgical operation. If we may accept a report that recently appeared in a London newspaper, a victim of multitudinous operation lives at this day in Paris in the person of a man named Landon, who recently appeared before the judges of the Second Chamber. He had undergone no less than eighteen surgical operations, and had been trepanned three times. One is not surprised to hear that his body is a mass of scars, for most of the great surgeons have used the knife on him. He appears to have passed most of his life in prison or in hospital, and was recently sentenced by default to five years' imprisonment for theft. We are told that he has already bequeathed his skull to the Faculty of Medicine. It really seems as if Landon were as great a testimony to the marvellous resisting powers of the human frame as to the wonders of modern surgery. We are glad to know that in consideration of his many sufferings the Court reduced his sentence considerably.

Hydros.—Past and Present.

In a clever and witty recent article in the *Manchester Dispatch* "An Experienced Dyspeptic," who has evidently seen many summers and a few winters, tells of the modern hydro as he finds it. The hydro is not as it used to be. Years ago the visitor was given pale green gruel, prefaced by family prayers, for supper, and at unseemly hours slumber was broken in order that drill might be performed before breakfast. Now the hydro has become, according to the "experienced dyspeptic," a place of pleasure and a haunt of fun. "Marriages" he writes, "may be made in heaven, but the preliminaries are carried out in your modern hydro." They are gayer than hotels, in spite of the fact that the fun derives no artificial stimulus from purple claret or bubbling hock. One "sad dog" of a clergyman, whose motto appeared to be "our pleasures are not here below," proved a positive deadweight at Sunday Concerts, and though he sat through a rendering of the "Holy City," and managed to abide a recitation entitled "Grandma's Day," left incontinently after a young man had finished "You should see me dance the polka with my coat-tails flying round." Cards were produced after the concert, and bridge with pecuniary accompaniments became the order of the day. "One lady, old enough to know what she wanted to do, kept a lighted cigarette in her mouth." Tennis, bowls, and coach-rides attracted those who enjoyed the open air. "It was the Continental Sunday, except that the town band did not play and you could not take a bath." Yet there was much chapel-going, and places of worship to suit all creeds were at hand. At another spa things were not so lively, but there was plenty of open country round for "light communion between the sexes. Seats were provided." But though the attractions indoors were not sufficient to counteract the open air cure, "there was a stage on which Pierrots sang and pirouetted, and revival meetings in a tent where the inhabitants groaned with pleasure." We can only say that for people who like such places, they are just the sort of places they are likely to want.

"Dr. Hawkins, M.D., U.S.A."

WEEK by week the public are being supplied with object lessons as to the worthlessness of the quack medicine trade. We are glad to acknowledge the suddenly awakened activity of the police in this important matter, on the principle of the old tag, "Better late than never." At Brighton they have secured the committal for trial at Assizes of the two Hawkins, father and son, on a charge of obtaining money under false pretences by means of powders called "Gloxiensis" and "Corrassa Compound." The composition of these cure-all remedies was stated to be bromide of potassium and other drugs costing a few pence, whereas they were sold at something near a pound. One point in this case may be commented upon generally. There is no attempt to deny that the defendants traded under the names of several clergymen and of "Dr. Hawkins, M.D., U.S.A." Now it is clear that anyone claiming to practise medicine in this country under that title would have to prove his possession of a recognised degree, and would be bound by the rules of the profession in England. Why should a man be permitted to sell medicines claiming to cure palpitation of the heart and a number of other specific affections under a fictitious name, and therefore a fictitious American qualification? Perhaps the General Medical Council might investigate this point, even if it be a little outside the strict letter of their constitution. It certainly affects the working value of the *Register*.

Holmes and Semmelweis.

IT would appear as if the tardy honour received by Oliver Wendell Holmes on account of his discoveries regarding puerperal fever is likely in some degree to diminish the fame of Semmelweis. It is natural, therefore, that a countryman of the latter, Dr. Győry of Buda-Pesth, should think it right to distinguish between the works of these two great men. He points out, without in any way diminishing the merits of Holmes, that the discoveries of Semmelweis were not merely in advance of the views of Holmes, but were in a certain way opposed to them. Holmes fought for the position that puerperal fever is a contagious disease; Semmelweis proved that puerperal fever and pyæmia are essentially the same process, or, to put it in modern phraseology,

that puerperal fever is a form of sepsis. We know now that both were right, though we do not, with the stricter contagionists, regard puerperal fever as specific. In Semmelweis' time, however, the gap between the two views was a wide one, and Semmelweis devoted much of his later writing to combating the contagionist view. It is a psychological fault that the public is in the habit of tagging to any great advance in science some one name, forgetting that discoveries are rarely sudden or the work of one man. It does not take any of the honour from Lister that he was preceded by Pasteur. Neither is Semmelweis' merit the less in completing the edifice of which Holmes had laid the foundation, and of which long before Holmes, Gordon of Aberdeen had mapped out the lines.

A Return to Vitalism.

Sir James Crichton-Brown touched on many interesting topics in his discursive address to the Leeds School of Medicine last week, but he himself seemed to think most important his criticism of the materialistic school of physiology. There is little doubt that the medical student, and, though to a much less extent, the practising physician, tend towards a materialistic view of the universe. In chemistry and physics and such studies we are accustomed to deal with matters which receive sufficient explanation on the basis of a materialistic theory. There are many things in life which cannot be so explained, but as they are not forced on the attention of the medical student, he is liable to overlook them. Sir James Crichton-Browne's protest against the application of materialistic theories to physiology is therefore not misplaced. He emphasises the immense difference between a living cell and a dead crystal, and he points out that no chemical process yet known can start a living process. No mixture or combination of elements can make live protoplasm. It is possible that Sir James protests a little too strongly, and that he is hasty in assuming that because the beginnings of life have so far escaped notice, they will always remain unobserved. Nevertheless, he is right in maintaining that when chemistry and physics have said their say, there yet remains much unexplained. It is, of course, of no avail to call such unexplained matters "vital phenomena," unless the phrase be regarded as a statement of ignorance. In the present stage of our knowledge, we must leave the explanation of such matters to speculation, but it is well to delimit as accurately as we can the field of speculation from the realm of science.

Pharmacists for the Army.

There is no doubt that there has been just cause for dissatisfaction as to the status and capability of the pharmaceutical service of the Army. This became most marked during the late war, when it was due, at least in part, to the fact that in their anxiety to obtain a sufficient number of dispensers, the Army authorities were not very particular in their choice. As a result, a number of pharmacists, broken down in health or unfit for ordinary civilian work, found their way into the service. It is proper that the subject should in time of peace receive full discussion, as the onset of another war would otherwise find things in much confusion. Surgeon-General Evatt, already well-known as an energetic reformer, has come forward with a scheme which, whether accepted or not, is likely to do good by giving a centre for discussion. He urges that there should be established a reserve of fifty pharmaceutical officers, who should, in war time, do duty in the larger military hospitals These gentlemen should be commissioned officers ranking as second lieutenant, lieutenant, captain, or major. There should be only one major, who should be commanding officer of the corps. They should, while on reserve, do a certain period of duty in a military hospital each year, so as to train them in military discipline and the routine of the service. Surgeon-General Evatt suggests a reserve fee of £25 a year, and pay during war service of ten shillings a day for second lieutenants, and so on in proportion. We are not sure that the officers of the Royal Army Medical Corps would welcome the establishment of a separate corps of commissioned officers whose quasi-independence might prove misleading, but no harm can result from a fair discussion of Surgeon-General Evatt's scheme.

PERSONAL.

Dr. Fred Carter, who has been in practice at Billericay for the long period of forty-four years, has been presented with an address and a handsome testimonial by his many patients and friends.

Professor Flinders Petrie, F.R.S., will deliver the seventh Annual Huxley Memorial Lecture before the Anthropological Society of Great Britain and Ireland in the Civil Service Commission Theatre, Burlington Gardens, at 8.30. p.m., November 1st, on the subject, "Migrations."

The Board of Governors of the Norfolk and Norwich Hospital recently presented an illuminated address to Mr. Charles Williams, F.R.C.S., on his resignation after thirty-six years' service as honorary surgeon to the Institution.

It is announced that the name of Dr. W. T. Parker Douglas, of Speen, Newbury, has been placed on the Commission of the Peace for the county of Berks.

The Harveian Oration at the College of Physicians was delivered by Professor Osler last week. The subject was "The Growth of Truth."

A bazaar will be held in aid of the Maternity and District Nurses' Home at Canning Town on December 13 and 14. Princess Henry of Battenberg has graciously promised to perform the opening ceremony.

Mr. John Humphry will shortly complete his fiftieth year of service as Medical Superintendent in charge of the Bucks County Lunatic Asylum, and the Visiting Committee of the asylum is inviting subscriptions to a testimonial to mark the public sense of his able and conscientious discharge of duties "which have been performed to the entire satisfaction of the committee, to the advantage of the county, and with uniform kindness and consideration for the unfortunate patients under his charge."

A CLINICAL LECTURE
ON
SURGICAL ASPECTS OF TUBERCULAR PERITONITIS. (a)

By FRANCIS J. STEWARD, M.B., M.S.Lond., F.R.C.S.Eng.

Assistant Surgeon to and Surgeon-in-Charge of the Throat Department, Guy's Hospital, Surgeon to the Hospital for Sick Children, Great Ormond Street.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

GENTLEMEN,—Before going on to the surgical aspects of tubercular peritonitis and its clinical manifestations, which I mean to discuss together, I think I shall perhaps clear the ground by dealing with some of the pathological points, and also with the question of surgical treatment and its rationale.

With regard to the pathology of tubercular peritonitis, the disease begins either as general miliary tubercle all over the peritoneum, or as local tubercular disease attacking, say, the Fallopian tube or the appendix, and gradually spreading from that primary focus. The great majority of cases are of the miliary form. The onset is generally rather acute as regards the development of tubercles, though not always as regards symptoms.

The tendency, in tubercular peritonitis, is towards the production of one or more varieties. There are three main varieties which it is important to remember. The first variety is what is generally spoken of as the ascitic form of tubercular peritonitis, in which the main symptom really is the production of ascites. The belly becomes distended with fluid, and the inside of the peritoneum is studded with little grey tubercles. Secondly, there is the form known as the plastic variety, and this may in certain cases be an early form of the ascitic, in which there is a certain amount of plastic lymph and a smaller amount of thicker fluid than in the ascitic form, and again the peritoneum is studded with tubercles. The parts which become chiefly affected are the omentum and the mesentery. The omentum in a child, for instance, instead of being quite thin, may be several inches in thickness. I shall presently show you a case illustrating that. The third variety that one sees is the caseating form, which is possibly the later form of the second or plastic variety, and in which there is a great tendency to the formation of adhesions and caseating foci. The intestines get stuck together and studded with caseating tubercles, and the walls become softened. Because of the caseation you get little loculi of pus and these often communicate with the intestines. In short, the whole abdominal cavity becomes a mass of adhesions and loculi of caseating material and fæcal matter. Very frequently, also, external sinuses or fistulæ develop, particularly at the umbilicus. If you see a child who is very ill, and has got a swollen abdomen and a red patch or sinus at the umbilicus, you may be certain that it is suffering from tubercular peritonitis. Another variety which I might mention is really a result of healed tubercular peritonitis, the fibrous form, in which there is no active tubercular disease but as a result of previous tubercular disease fibrous tissue is formed, and practically the whole of the abdominal contents become matted together and converted into a solid mass. This condition of things is liable to give rise to intestinal obstruction.

Just a word with regard to the surgical treatment, and I am not going to deal with any other form of treatment except the surgical; though, of course, I do not want by any means to suggest that there is nothing to be done in tubercular peritonitis but to operate. First, I may mention the fact that the real value of simple laparotomy in cases of tubercular peritonitis was discovered accidentally. In cases of mistaken diagnosis laparotomy was performed for some other disease, or for diagnostic purposes, and tubercular disease was found. Nothing was done, and the abdomen was closed up, and the patients rapidly got well. It was these mistakes, leading to the patients getting well, which really started the practice of operation for cases of tubercular peritonitis. Nobody knows how it is that the patients are so greatly benefited by laparotomy, especially in the plastic and miliary and ascitic forms of the disease. It seems most likely that the admission of light or air, or both, into the abdominal cavity produces some influence upon the disease process which tends to arrest it.

With regard to the final results of laparotomy, in cases of tubercular peritonitis, different observers give different percentages, but all agree that in nearly all cases the patients improve for a certain time. Rouel collected 358 cases in which laparotomy had been performed, and he found that 75 per cent. were either improved or cured. Watson-Cheyne gives 50 per cent. as improved or cured. Treves says that 35 per cent. are cured, and many are improved. Considering that a very large proportion of cases of tubercular peritonitis go downhill rapidly if not operated on, I think that these figures form a very strong argument in favour of surgical treatment.

From a *clinical* point of view, it is important to remember that tubercular peritonitis is quite an extraordinary disease in the many ways in which it develops. The cases that I am going to describe to you will illustrate that very well, and also, I trust, help you to realise that in any difficult case of abdominal disease that you have to tackle, you should always ask yourself the question, "Is this tubercular peritonitis?" By doing this, you will find that very often you will avoid a mistake.

This boy that I now show you was in Clinical ward, and was operated on on the 27th of February, 1905. As you will see, his abdomen is its normal size. It was enormously distended, owing to very marked tubercular peritonitis of the plastic variety. As it is more than a year ago since the operation was performed, and he appears to be quite well, he may, I think, be considered to be cured.

We will now consider some other cases. I have tried to divide the cases up into different groups. First, there is the *acute form*, which is frequently diagnosed as some disease differing altogether from tubercular peritonitis. I will first describe the case of a woman, 22 years of age, who was admitted into Clinical ward on July 12th, 1903. The notes state that she complained of severe pain in the abdomen. She was taken suddenly ill five days before admission with acute pain all over the abdomen. The pain was followed by sickness, and the symptoms got daily worse until the time of admission. When I saw her she was very ill, cold, and collapsed, her pulse was 120, and she was incessantly vomiting. Her abdomen was rigid and boardlike all over, and did not move on respiration; it was also tender, but more tender below than above the umbilicus. From the signs and symptoms we judged that the case was one of acute general peritonitis due to appendicitis. The only dubious point about the case was that whereas patients, three or four days after the onset of peritonitis, usually have a subnormal temperature, she had a temperature of 102 degrees. I operated, making an incision over the appendicular region, and, instead of finding that she had appendicitis, I found that she had the plastic form of miliary tuberculosis. All the peritoneum on the intestine, mesentery, and omentum, and down into her pelvis, was studded over with myriads of tiny tubercles. There was also a little fluid. The appendix was not affected at all, and I did not remove it. We put stitches

(a) A Clinical Lecture delivered at Guy's Hospital, Friday, May 25th, 1906.

into the abdominal wall, and put the patient back to bed. Her temperature came down, and all her other symptoms disappeared, and at the end of three weeks she left the hospital well. Only a short time ago I heard that she is still quite well.

The next case was a child admitted into Clinical ward about the same time as the last case. She was admitted for acute pain in the abdomen, vomiting, a tender, rigid abdomen, and she was also passing blood from her rectum. It was thought that, as she was passing blood, she might have intussusception or peritonitis. But she was so excessively ill that I did not think she would be able to stand an operation, and no operation was done. She was put to bed and given salines and strychnine, and she slowly but gradually improved—so much so that she was sent away to a convalescent home. Now comes the interesting point. That child was re-admitted three months afterwards with a fistula at the umbilicus and, obviously, well-marked tubercular peritonitis. These two cases serve very well to illustrate the *acute form* of the disease.

We now come to the second group, which is perhaps more commonly met with. In this group of cases the disease is not usually recognised very soon, because its onset is very insidious. The patient does not seem well, the bowels are irregular, he loses flesh, the temperature is sometimes up and sometimes normal. But one feature which stands out is that, while the patient loses flesh generally, he gradually develops ascites. I will read you some of the chief points about a case which will illustrate that very well. A young woman, aged 16, was admitted, under Dr. Pitt, on June 15th last year. A month before admission the patient had pain in the upper part of the abdomen, which began to swell, and gradually became more and more distended. Her bowels were irregular, she had profuse sweating, night and day, and lost flesh. When admitted, her temperature was raised to 100-101 degrees every day practically, and she had well-marked ascites. After she had been in some little time, and had not improved, I was asked to see her, and strongly recommended operation, feeling sure that she was suffering from tubercular peritonitis. Twelve days after she came in I operated. The patient was given an anæsthetic, and I made an incision three and a half inches below the umbilicus. The peritoneum was found to be thickened, and on opening it, some fluid escaped. Tubercles were found on the peritoneum, and some of them seemed to be caseating. There was also some lymph on the intestines. This was, then, a case of the ascitic form of tubercular peritonitis, and it seemed as if the disease was advancing, because some of the tubercles were apparently caseating. The temperature came down soon after the operation, no re-accumulation of fluid took place, and the patient went out on July 23rd. She returned again at the beginning of this year with a stitch sinus. There was no sign of any return of the disease, and she is to all intents and purposes perfectly well, and looks a different girl.

Here is another case of the ascitic form. A child, æt. three, complained of pain a month before admission. His mother noticed that his abdomen was swelling. He had more or less severe attacks of pain every day which made him scream. His bowels had kept regular, but the motions were loose. The abdomen continued to increase in size, and the patient was noticed to be short of breath two days before admission. At the time of admission the abdomen was tender and distended, dull in the flanks and resonant in front. The evidence of ascites increased rather than diminished. After the patient had been in for some little time, I saw him and recommended that an operation should be performed. He had been admitted on November 29th, and a laparotomy was done on February 1st of this year. A tremendous amount of fluid escaped, and the peritoneum was studded with small grey tubercles, a few of which showed evidence of caseation. The patient had no re-collection of fluid, and did well from that time, and went out on March 31st. He is up here again to-day, and you will see that he is quite well. So much for the ascitic form. Both of these cases, as we saw, had a lot of fluid. Other cases, however, in which the onset is slow and insidious, do not get ascites, but some other form of tubercular peritonitis.

I had such a case at Great Ormond Street recently, a child, æt. five, who for four months had been ill. He was very thin, his skin was dry, and he had a big, distended abdomen, but no evidence of fluid. It was thought that he had probably got tubercular peritonitis. He was not expected to recover, because he was so extremely ill and wasted. But, in view of the unexpected cures that do take place after laparotomy, I decided to operate. I opened his abdomen and found the intestines matted together by masses of adhesions, and there were numerous loculi full of caseating tuberculous material and pus, and owing to the action of the bacillus coli the pus stank like an appendicular abscess. I had to be extremely careful to avoid tearing holes in the infiltrated intestines. Very soon after the operation the intestine gave way in several places, fæces poured from the abdominal wall, and the child very soon died.

In the third group I have put down *cases resembling typhoid*. Four years ago I operated on a very interesting case of that kind. A boy, æt. seventeen, was in the South-Eastern Fever Hospital, and was thought to have typhoid. A month afterwards it was decided that he was not suffering from that disease, and he was transferred to Guy's and placed under the care of Sir Cooper Perry. He was found to have a distended abdomen, his temperature was uniformly high—103 degrees or 104 degrees—and he had signs of fluid in the abdomen. I was asked to see him, and decided to operate. Under cocaine anæsthesia, I opened the abdomen and found that the peritoneum had tubercles all over it, and that his omentum and mesentery were enormously thickened. He had also a fairly large amount of fluid, which was let out. The wound leaked for some days, but eventually healed, and the patient went out apparently quite well and weighing 2st. more than when he was first brought in. That was four years since, and he was up here a year ago quite well. I mention that case to show you how very important it is, when you have doubtful cases of typhoid, to think of tubercular peritonitis.

We now come to another group—those *cases which resemble appendicitis*. In this group comes the case of the boy whom I showed you a few minutes ago. He had been ill a month. His illness began quite suddenly, so that it was really an acute case. He had been playing at football, and on the following day he was taken ill, had pain over the appendix area, and vomited several times. The pain continued off and on for three weeks, and three days before admission he returned to bed with pain over the same area, and a temperature of 101°-103°. There had been no constipation, but rather a tendency to diarrhœa, and no vomiting since the attack a month before. When the patient was admitted his abdomen was found to be full, but moved well, excepting over the appendix area, which was tender to touch and slightly rigid. There was also bulging into the anterior wall of the rectum. Although we thought he had appendicitis, yet we were struck by the fact that he looked remarkably well for a child who had been suffering from appendicitis for over a month, and this feature of the case determined me not to operate at once, but to keep the patient under further observation. The temperature, on the second day after admission, was 101·4 degrees, and after going down a little rose to 102 degrees. Five days after admission it was 103·8 degrees, and the patient seemed more ill. On the following day I operated, and found some coils of intestine adherent to one another and to the anterior abdominal wall. On passing the finger into this part of the abdomen between the coils, a certain amount of blood-stained serum escaped—two or three ounces. The cæcum was free, and so was the appendix, but the omentum was enormously thickened with tuberculous growth, which we thought at first was a great mass of sarcoma. The wound was closed, and from that time the patient steadily got well, and he has been all right

ever since. That shows how closely a case of tubercular peritonitis may resemble appendicitis.

The last group of cases that I want to mention to you are cases in which the disease is *causing intestinal obstruction*. A woman, æt. nineteen, was admitted under Dr. Taylor, on November 16th, 1901. From May to September she had had continual headaches, and her eyes were bloodshot. She was given some medicine, and this cured her headaches and her eyes became better. On October 22nd she vomited and had pain across the abdomen. The abdomen became distended, and the patient suffered from constipation. Beyond these symptoms there was nothing definite made out by examining her abdomen. She was given enemata, but it became more and more difficult to get her bowels opened. Her abdomen got increasingly distended, and eventually she began to vomit. Dr. Shaw, one night, asked me to see her. He diagnosed intestinal obstruction, and advised operation. Accordingly I operated, making an incision from just below the umbilicus to the pubes. Enormously distended coils of intestine were found, and the peritoneal surface was seen at once to be studded with small tubercles. Two of the most distended coils were punctured, and a large quantity of gas and fluid fæces escaped. The cause of the obstruction was then found to be at the site of the appendix, which, as the result of the tuberculous disease, had become partially adherent to the mesentery, so forming a band beneath which a loop of small intestine had passed and become compressed. The appendix was removed, the wound was closed, and the patient was but back to bed. This then was a patient who had intestinal obstruction and also tubercular peritonitis. I removed the obstruction, but nothing was done for the peritonitis, and the patient went out perfectly well six weeks afterwards.

I have got notes of one other case of obstruction caused by tubercular peritonitis, but it is a case of a different type to the last. Here the obstruction was not due to the actual presence of tubercular peritonitis, but to dense adhesions which were the result of a cured tubercular peritonitis. The patient was a man in Stephen ward under Dr. Beddard. He had a very long history of constipation, and when he came in it was quite obvious that he was suffering from intestinal obstruction. He was constantly vomiting, and neither enemata nor drugs had had any effect. I operated, and found that practically all his intestines were tied up into a solid mass by fibrous adhesions. There were kinks and numerous patches of distended and twisted gut. I opened some of the coils of intestine and let out the fluid, and sewed the holes up again, but practically no good could be done, because the bowel was kinked everywhere, and the man died two or three days afterwards. This case illustrates the way in which a cured tubercular peritonitis may produce obstruction.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week's number will be by R. F. Tobin, F.R.C.S., Surgeon to St. Vincent's Hospital, Dublin., on "Urethral Impediments to the Evacuation of Urine." Lecture delivered to Senior Students at St. Vincent's Hospital.*

AT Selkirk School Board on October 15th, it was reported that several children had been examined on account of the recent outbreak of diphtheria in the town and out of 41 so examined, 8 were found to have bacilli in their throats. Out of another batch of 78, 12 were found to be affected, and the fear was expressed that when others were examined other cases would be reported. No fewer than 60 were absent from one school that morning. It was curious that although bacilli were found in the throats of the children, there was no sickness

ORIGINAL PAPERS.

THREE CASES OF UTERINE FIBROIDS OF UNUSUAL INTEREST (a).

BY F. BOWREMAN JESSETT, F.R.C.S.,
Senior Surgeon, Cancer Hospital, Brompton, etc., etc.

Case I.—UTERINE FIBROIDS—CALCIFICATION—CŒLIOTOMY—FIBROIDS REMOVED—RECOVERY.

S. J., widow, æt. 51, no family, was sent to me by Dr. Frazer, of Brighton. Admitted into Cancer Hospital on September 15th, with the following history:—

History.—About seven months ago health failed, and suffered pain in left side of back, radiating down left leg, with a feeling of contraction in the leg when walking. The pain steadily increased, and difficulty in walking became more pronounced, until now she can get about only by using a stout stick. Bowels regular, and no difficulty in micturition. No vaginal discharge. Climacteric two years ago.

Previous History.—Ten years ago left breast was removed by me at the Hospital for Scirrhus. There was no recurrence for three years, when she presented herself again with recurrence in axilla. This I removed, and a third operation was performed in the same axilla after another three years. Since this operation, four years ago, there has been no recurrence.

Present Condition.—The woman looks pale and ill, with anxious expression of countenance. Has been steadily losing flesh during the last few months, complains of constant pain in her back, and difficulty in walking. Abdominal examination reveals little; the abdominal walls are flaccid, and no enlargement, but by deep pressure over the uterus there is some resistance, and pain is accentuated. Per vaginam the os and cervix uteri are found to be somewhat hard, but not enlarged. Bimanually, a large, somewht irregular lump can be felt in the right fornix, which is evidently connected with the uterus. The fundus of the uterus is prominent, and several hard nodules can be felt connected with it. Uterus is quite mobile.

On September 18th I performed cœliotomy, the patient being placed in extreme Trendelenburg position. A hard nodular tumour the size of a cricket-ball readily came in view, pedunculated and fixed to the right corner of uterus. On withdrawing this the attachment to the uterus tore through, although only slight traction was made. I transfixed the pedicle, and ligatured it. Three other smaller growths were brought into view attached to the posterior surface of the uterus. By dividing the peritoneum over them they were readily enucleated, the bleeding being arrested by deep catgut sutures, and the peritoneum carefully closed over.

Another larger growth the size of a hen's egg was found on drawing the uterus out of the wound, situated on the posterior surface of the organ. This was enucleated in a similar way to the others, the capsule being stitched with catgut.

The abdominal wound was closed in layers, the peritoneum united with catgut, then four silkworm-gut sutures passing through all the tissues excepting the peritoneum acting as supporting sutures; then the aponeurosis was united with continuous sutures, and the skin also by a continuous suture, the four silkworm-gut supporting sutures being finally tied.

Ten days after the sutures were removed, and patient has made an uninterrupted convalescence.

Remarks.—This case is of interest on account of the relative absence of symptoms leading one to suspect the presence of fibroids of the uterus. There was no enlargement of the abdomen, no interference of the functions of the rectum or bladder, and no hæmorrhage. In fact, the patient applied only on account of the pain in the left side of the back and pains down the leg, which caused her to walk with great difficulty. When she consulted Dr. Frazer he, on examination, discovered something in the pouch of Douglas, and sent her to me, as

(a) Cases shown and notes read before the British Gynæcological Society, London, October 12th, 1906.

I had operated on her on previous occasions for carcinoma of the breast, and it was feared there might be some secondary growths in the pelvis.

The case also shows the advisability of in all cases examining the pelvic organs when women complain of pain extending down the nerves of the leg, as no doubt the pressure of a tumour on the sacral and lumbar plexus must often be responsible for these pains, and if these are not discovered any amount of local or general treatment will be of little avail in relieving the patient of her symptoms; whereas if a tumour or growth is discovered, and can be removed, the patient is at once relieved of her symptoms, and enabled to enjoy life again.

The case is also of interest on account of the calcification which has taken place in the tumours. They are, as you see, entirely calcified, and it is comparatively rarely that such a condition exists. They are usually present in elderly women, some years past the menopause. When occurring before this the tumours are always, I believe, as in this case, either subperitoneal or pedunculated subserous growths, in which the means of nourishment are extremely slender. In elderly women all varieties of fibromyoma are liable to calcification, and may exist in either of two forms—peripheral or interstitial. In the former and rarer variety a thin, rough, chalky deposit is found on the surface of the growth only; in the latter, there is an infiltration of lime salts throughout the thickness of the growth, which may be localised in patches, or invade the whole mass. Where peripheral calcification is complete, the centre of the tumour usually becomes necrotic from complete arrest of its circulation.

The calcified tumours have been known and described so long ago as Hippocrates and other ancient authors. One of the largest calcified tumours, described as weighing 2lb. 5½oz., is now in Edinburgh Anatomical Museum, and was found in a grave within the pelvis of an apparently elderly woman.

The case is further of interest on account of her having had carcinoma of the breast, which had been removed ten years previously, and that although she had had recurrence on two occasions, she had been free from such recurrence for at least four years.

I have at present under my care another similar case, in which I removed a large fibroid tumour several years previously, and where I had removed the breast for scirrhus. In my practice I have only had very few such cases, so that the coincidence of fibroids following carcinoma cannot be very common, and probably is of no significance, although it has been stated by some authorities to be so.

Case II.—Case of Severe Menorrhagia—Fibroid of Fundus—Vaginal Hysterectomy—Recovery.

E. L., widow, æt. 49, seven children. Admitted into Cancer Hospital, September 15th, 1906.

History.—Enjoyed good health until about a year ago, when she complained of general weakness and debility. Had always been quite regular, not excessively so, up to this time, when menstruation became irregular and fitful, sometimes losing excessively. She took little notice of this, thinking it was "change of life." She would be quite free from any loss perhaps for six weeks at a time, then a severe loss of blood would occur, lasting on and off perhaps for a month, passing at times large clots. These attacks have become more frequent lately, coming on often quite suddenly, until now she has become pale and weak, and more or less a confirmed invalid. Suffers slightly from constipation.

Previous History.—Never suffered from any severe illness; a big-framed woman, and been accustomed to work until present illness.

Present Condition.—Pale, anæmic appearance; pulse, want of tone; complains of general lassitude and disinclination to do anything. The abdomen is soft and flaccid. No tumour can be felt. Per vaginam, the walls are lax, and a quantity of leucorrhœal discharge. In Douglas' pouch a good-sized tumour can be felt, smooth and apparently fixed. The os was soft and papulous, the lips thick, and a finger could be almost passed. I took the lump in the pouch of Douglas to be a retroverted uterus. By firm pressure it could be pushed upwards to the brim of the pelvis. Bimanually, this was found to be enlarged and smooth.

The question of diagnosis was not altogether easy, as the menorrhagia might be caused by one of three conditions—viz., uterine polypi, submucous fibroid, or carcinoma of the fundus. I gave it as my opinion, however, that it probably was caused by a submucous fibroid.

On September 18th she was anæsthetised, and placed in lithotomy position on the operation table. The uterus was readily drawn down through the vagina with Vusellum forceps, and I dilated the canal up to 21 Hagar. Owing to the great length of uterine cavity, digital examination revealed nothing. I decided to remove the organ, which was readily done in the usual way.

The patient made an uneventful convalescence. On cutting open the uterus a fibroid the size of a walnut was, as you see, found in the fundus uteri close under the mucous membrane, and was the cause unquestionably of the hæmorrhage and the retroversion.

This case represents one of a number of cases which have been under my notice in which patients have been allowed to go on for months and years continually losing large quantities of blood, and becoming anæmic and useless members of society, spending a large part of their time in bed, being dosed with ergot, iron, and other drugs without any good effect. At the end of the period, which usually lasts a week or ten days, they get up, only to repeat the same process in a week or two's time. The diagnosis is, as in this case, not always easy, as the loss may be caused by several different conditions; but in all such cases I consider a most careful examination of the uterus should be made, and if nothing is discovered by ordinary digital examination or by the speculum, the patient should be placed under an anæsthetic and her uterine cavity dilated and explored, and if no polypi be found, the uterus had better be removed. I have seen many cases in which women have been suffering from severe menorrhagia, in whom the uterus has been curretted, often several times, without any good accruing. At last, by full dilation and exploration a submucous fibroid has been found, and in some cases fairly readily removed, and the patient's symptoms relieved.

Case III. is one of peculiar interest. It is a case which I was asked to see by Dr. Wickham, of Fleet, to whom I am indebted for the following:—

Notes.—E. H., married, æt. 46, eight children, youngest 2½ years old. Instruments used at confinement on two occasions, always convalesced well after confinements, being up and about in a fortnight.

Has never suffered from leucorrhœa. Urination normal until present illness, when about a month previous she thought she noticed she had to pass water more frequently than usual. Menstruation regular.

Remembers seven years ago after one of her confinements having an attack of severe vomiting, accompanied by great abdominal pain, which lasted twenty-four hours, but left no bad results, and she was quite well in a day or so.

Last May (four months prior to present illness), had a severe attack of abdominal pain, no vomiting. This only lasted for twenty-four hours, and she was able to get about again the following day.

Present Illness began five weeks before Dr. Wickham saw her, with pain in abdomen, which rapidly became worse, accompanied with vomiting during the night; this subsided. She was given an opium pill, which kept her comfortable the following night. Next day she was seen by her doctor, who found the abdomen a good deal distended and tender on palpation. Temperature 102, pulse 100. Bowels had not been open since the beginning of the attack. A large enema was administered, but produced but little effect. She then took, on her own initiative, a dose of castor oil, which caused vomiting the whole night. A large turpentine enema was given and bowels were copiously relieved, and the distension of abdomen disappeared. The temperature, however, remained high, never falling below 100-101, for the next two days. A vaginal examination at this time revealed the os uteri slightly pushed forward, and a smooth elastic swelling could be felt

in the pouch of Douglas. At this stage Dr. Wickham asked me to see the patient with him; the swelling in pouch of Douglas had increased somewhat.

The abdomen was somewhat distended, and a distinct sense of resistance could be defined below the umbilicus. Bimanually this fulness was well marked, and evidently was one with the fulness in Douglas' pouch, which felt elastic and doughy. Fluctuation could not be made out. The patient complained of very little pain, and the examination did not cause her any great distress.

The question of diagnosis was difficult and obscure. We were disposed to think it might be a soft, rapidly-growing fibroid, or an ovarian cyst which was suppurating. It was decided, however, that an operation should be performed as early as possible.

On the following day, September 16th, assisted by Dr. Wickham, Dr. Wilcox giving the anæsthetic, I opened the abdomen between the umbilicus and pubes, when the intestines were found to be matted together, and extensive peritonitis present. In separating a coil of small intestine which was somewhat firmly adherent to the brim of the pelvis, a quantity of badly smelling pus welled up. This was carefully wiped away, and seemed to be localised to a pocket, at the base of which a considerable rounded swelling was seen filling the pelvis, the peritoneum over which was coated by a thick coating of lymph. I cautiously tried to free some of the other coils of intestine, but found them very firmly adherent, and being afraid of breaking into the swelling in the pelvis, which I was pretty sure contained a quantity of pus, I approximated the wound in the abdominal parietes by means of pressure forceps, and had the patient drawn to the bottom of the table and placed in lithotomy position, and then with a fine aspirating needle explored the swelling by puncturing it, when pus was withdrawn. I then with a bistoury made a free opening into it, and evacuated a large quantity of most foul-smelling pus. I made a very free opening into it, and wiped it out with gauze, and with the douche washed the cavity out, and then introduced a large drain of iodoform gauze.

The patient having been replaced in the prone position on the table, I again examined the abdominal cavity, and finding no sign of any pus, placed a drain of iodoform gauze on the lower angle of the wound, and closed it in layers. The temperature steadily fell, but remained somewhat high for the first week, when there was a sudden large escape of pus, through the abdominal wound evidently, and another pocket formed by the intestines.

The patient made an excellent convalescence, and is now—nearly a month after the operation—free from any discharge, and the wound in the abdomen firmly healed.

I venture to think this case is one of considerable interest and importance, both from a diagnostic point of view as well as to the best method of treatment.

What the cause of this abscess was it is very difficult to say. Whether it was caused by perimetritis, cellulitis, or a suppurating ovarian cyst, or could it be one of those cases of appendicitis in which the appendix became adherent to some of the pelvic viscera, becoming perforated and thus forming the abscess, it is difficult to say. Even at the time of the operation it was impossible to make out without breaking down the intestinal adhesions and freeing them from the pelvis, which proceeding I think would have been fraught with considerable danger to the patient.

With respect to the best operation to be performed in these cases, I should be glad to have the views of some of the Fellows of this Society. In the first instance I was disposed to explore the swelling in Douglas' pouch through the vagina with an aspirating needle, when of course I should have discovered pus and opened up the abscess cavity and drained; but then what about the two pockets of pus which were disclosed around the intestines by the abdominal incision? I am quite certain they were not connected directly with the abscess in the pouch of Douglas, and if not, clearly the patient would not have materially benefitted unless they opened later into the abscess cavity connected with the vagina.

Then, with regard to flushing the abdomen, I was asked why I did not. My reply was, we have the pus now limited to the cavity from which it had been wiped, whereas if I flushed the cavity out some of the pus cells might be carried to other parts of the abdomen which are at present uninfected. I should very much have liked to have examined the appendix, but I think I acted in the best interest of our patient by not venturing to disturb the adhesions which nature had apparently placed there to protect the other parts of the abdomen from infection.

I should have mentioned that in the first instance on which Dr. Wickham saw the patient the abdomen was much distended, and symptoms of some intestinal obstruction, which he feared might occur, were present; but after the administration of a large turpentine enema, the bowels were freely relieved, and the distension disappeared.

THE IMPORTANCE OF THE EARLIEST POSSIBLE RECOGNITION OF MALIGNANCY IN TUMOURS (a).

By FRANK T. PAUL, F.R.C.S.,

President of the Liverpool Medical Institution; Surgeon to the Liverpool Royal Infirmary, &c.

The author drew special attention to the diagnostic value of the microscope, and said that in dealing with new growths two mistakes were frequently made, either of which was sufficient to bring about a failure in treatment: one was waiting in the early and doubtful stages until malignancy was declared; the other was throwing the responsibility of the diagnosis on a pathologist who had never seen the case and had only a shred of tissue on which to base his opinion. If it was intended to ask a pathologist to make the diagnosis, he should also be asked to see the patient. Histology alone was not sufficient in difficult cases; either the clinician should be better trained in histology, or the pathologist should become a clinical pathologist. Most medical men had seen cases of cancer become hopeless whilst waiting under drug treatment until a certain diagnosis should be arrived at and an operation recommended. It was a small matter to snip off a papule or sore from the tongue or to excise a nodule from the breast in order that the necessary information might be quickly obtained. In spite of all that had been done by the brilliant band of workers in Cancer Researches, up to the present early and complete removal had proved the only reliable cure. Recurrence meant incomplete removal—though it was true that in some people the tendency to cancer was so inveterate that the cure of one growth might be followed by the development of another of a different type.

Discussing epithelioma of the tongue, the President said that he associated himself with Mr. Butlin in believing that it was curable, under favourable conditions. The early diagnosis could only be made with the help of the microscope. The difficulty generally lay in the differential diagnosis of epithelioma, papilloma, simple and tubercular ulcer. Epithelioma often began in syphilitic tongue, and it was to be feared that many lives were lost owing to the delay caused by the six weeks' specific treatment it was usually

(a) Abstract of Presidential Address delivered before the Liverpool Medical Institution, October 11th, 1906.

thought necessary to prescribe, while the microscope would often reveal in a specific or apparently simple ulcer a small centre of malignant disease. Butlin's radical operation was not too extensive for the smallest epithelioma of the tongue. Solitary tubercular ulcers of the tongue or lips might occur in apparently healthy subjects, and without microscopical examination be mistaken for epithelioma. Papillomata should be invariably removed, and if found to be undergoing malignant changes an extensive dissection should be performed, although the papillomatous form of cancer, because of its outward growth, was much less malignant than the ulcerous variety. Apparently innocent growths of the mouth were better snipped off and examined, if only to relieve the mind of the patient. Speaking of malignant disease of the maxillary antrum, Mr. Paul said that a reference to his note-books showed him that 20 or 30 years ago sarcoma was more common than carcinoma; he thought carcinoma was attacking younger people, whilst sarcoma was diminishing in frequency. Microscopic examination of fluid drawn off by the exploring needle, although the fluid might appear to be nothing but blood, occasionally enabled the surgeon to make a diagnosis of malignant disease. The value of the microscope was further shown in the diagnosis of cancer of the cæcum from appendicitis. Mr. Paul then discussed the varieties of fibromata, malignant and benign, skin tumours, implantation cysts and rodent ulcers. The latter disease was a true cancer of the sebaceous glands, was often multiple, and, contrary to the statement often made, it did occasionally infect the lymphatic glands. At its commencement rodent ulcer had to be differentiated from minute cysts and adenomata, from warts, moles, and epitheliomata. Complete removal (when possible) was more valuable than X-ray treatment.

The author then related a case of extensive epithelioma of the perineum, which he thought originated in an included remnant of epiblast in the mesial line. Carcinomata often began in imperfectly removed sebaceous cysts. The old idea that parotid tumours were always innocent was not correct, and growths which were at first innocent often became malignant. Salivary carcinoma was as malignant as breast cancer. Malignant diseases of the bladder and of the breast were then discussed, Mr. Paul's well-known views on the pathology of the latter being re-stated, and the importance of early microscopical examination in doubtful cases of disease of either organ insisted upon.

The address was illustrated by 71 lantern slides taken from Mr. Paul's micro-photographs.

THE DIAGNOSIS OF SOME FORMS OF DYSPEPSIA (a).

By WM. G. BARRAS, M.D., C.M., D.P.H.,

Hon. Physician to the Elder Cottage Hospital; Bacteriologist to the Borough of Govan, Glasgow.

Dr. Barras pointed out that, normally, the stomach occupies the left hypochondrium, the epigastrium, and part of the right hypochondrium, but as five-sixths of it are situated in the left hypochondrium, it follows that much the greater part lies to the left of the middle line. Part only of the stomach wall is to be found just under the abdominal parietes, viz., that in the epigastric region. The pylorus is level with the tip of the ensiform cartilage, in the right sternal line, and it, with the lesser curvature of the stomach, is covered by the left lobe of the liver, whereas the fundus is covered by the left leaflet of the diaphragm and lower anterior part of the left lung.

The tympanitic note of a normal stomach should cease about one inch above the umbilicus.

The term indigestion should be limited to cases where there is no organic or functional disease present, the cause of which is to be found in the food, which may be abnormal in quality or quantity. The importance of thorough mastication can scarcely be over-estimated, as bolted food is a fruitful source of indigestion. Improper arrangement of meals is another fruitful source of dyspepsia. Dr. Barras condemned the tea habit after meals, and what are called appetisers. Excess and defect in the supply of food leads to pathological conditions. Dr. Barras, in speaking of neurasthenia, said that, in that malady, we are dealing with poisoned and not simply with exhausted nerve centres, and pointed out the evils that may arise from constipation, the tea and tobacco habit in this connection. Agreeing with Dr. Herschell, Dr. Barras stated that in primary hyperchlorhydria, we have an excess of pepsin and hydrochloric acid, but secreted only at the normal digestive periods, and ceasing in the intervals, thus distinguishing it from hypersecretion. This condition is said to account for a fourth of all the so-called indigestions, and the greater part of all acutely painful dyspepsias. The common symptom present is, at first, uneasiness after meals, then, as the case advances, pain is commonly present two to four hours after a meal, and can be relieved by a large dose of alkaline medicine. In hypersecretion, the worst paroxysms are usually experienced at night. The patient may complain of cramps in the epigastrium and left mammary region some time after meals. The introduction of a meal of food relieves for the time being, by absorbing the acid. In anæmia, pain is not so severe and appears sooner after a meal. In ulcer, again, the pain often begins at once, on the taking of food, and is relieved by vomiting.

The neuroses of the stomach were discussed, paresis of the pylorus leading to diarrhœa. In hyper-excitability, we may have eructations, regurgitation of food, spasm of the cardiac or pyloric ends of the stomach, leading to a feeling of great distension, the patient being unable for a time to dispose of wind either upwards or downwards. Further, nervous vomiting may ensue. Dr. Barras cited a case under his care where a young lady had persistent vomiting of food without any obvious cause, which was relieved when she took rest in bed. She has been under medical care for a year, but no recognised method of treatment has done any positive good. Her loss in weight has not been serious. Dr. Barras referred to a case of bulimia, related by Reyer, where a lady, 32 years, after a long period of worry and trouble, was suddenly attacked with hunger, and within an hour consumed three pints of milk, 23 eggs, and two pints of wine, after which she fell asleep, and on waking was perfectly well. The presence of hydrochloric, in cases of ulcer of the stomach, was contrasted with that generally found in cancer, namely an absence of hydrochloric acid, with an excess of lactic acid. Dr. Barras concluded his interesting address, by discussing the question of gastric neurasthenia.

(a) Abstract of a Presidental Address delivered Oct. 17th, 1906, before the Glasgow Eastern Medical Society.

CLINICAL RECORDS.

VENESECTION IN URÆMIA.

BY W. E. WATERS, L.R.C.P. & S.I.,
Medical Officer, Carbury Dispensary District.

ON the 6th inst. I had a case of uræmia in a girl æt. 22, which had grown worse since the day before, in spite of ordinary treatment. I could not gather from the history how long there had been albuminuria, but on this day the urine was loaded with albumen and very scanty. She had intense headache and constant vomiting of quantities of bile; pupils widely dilated, and total blindness—she could not even see where the window was. She had occasional hallucinations, but was rational between them. Temp. 102, pulse 110. No pulmonary œdema. Respiration normal. Seeing there was no time to lose, I took 18 ozs. of blood from the arm. There was not any decided improvement that night or next morning; so I then (24 hours after the first bleeding) removed another 18 ozs. of blood. She soon appeared better, and from that improved so rapidly that on the 10th inst. there was not a trace of albumen in the urine, and she felt quite well, except for the natural amount of weakness.

THE OUT-PATIENTS' ROOM.

ROYAL FREE HOSPITAL.

Multiple Gummata of the Tongue.

By T. P. LEGG, M.S., F.R.C.S.

AMONG the out-patients was a married woman æt. 37, who presented herself suffering from two ulcers on the dorsum of the tongue. She stated that these had been present for some weeks, that they had caused very little pain, and that they had begun as small lumps in the substance of the tongue. On examination, there was seen to be a deep ulcer with sharply-cut edges on the right of the dorsum to the right of the middle line, and round the ulcer there was a good deal of thickening. On the left side of the tongue at its posterior part there was a second smaller but otherwise exactly similar ulcer. The bases of the ulcers were quite smooth and covered by a yellowish slough. The tongue as a whole was considerably enlarged, its margins were indented by the teeth, and the papillæ had disappeared over the greater part of the dorsum, the epidermis being thickened, with the characteristic appearances of chronic superficial glossitis. There was no interference with the mobility of the tongue, which could be fully protruded. The mouth was in a filthily dirty condition, there being many septic stumps in both the upper and lower jaw. The glands on the left side of the neck in the submaxillary region were considerably enlarged; they were not tender or painful. Under the treatment they diminished in size as the condition in the tongue improved.

As far as the past history was concerned, the only evidence pointing to syphilis was the fact that she had had three miscarriages. The diagnosis of the condition was obviously multiple gummata. Mr. Legg said that the case illustrated how extensive the disease may be without in any way interfering with the mobility of the tongue, thus offering a marked contrast to carcinoma, where even a small mass or one limited to half the tongue will produce great interference with the movements of the organ. The next point the case illustrated was the importance of the septic condition of the mouth in many of these cases, and the necessity of getting rid of this factor by local treatment. Hence it was advisable to remove all decayed stumps, to insist upon the regular use of a toothbrush, so as to cleanse the gums and the teeth. Mr. Legg also thought that the local application of a mercurial preparation such as glycerine of perchloride of mercury, 1 in 2,000, would be of great value, in addition to the internal administration of iodide of potassium. In some cases, he said, where the tertiary symptoms do not yield to iodide of potassium, one finds that mercury administered internally in small doses will be of benefit, and the *hydrarg. cum creta*, in the form of a pill *bis die*, is one of the best preparations to employ. Whether the enlargement was a gummatous condition or one due to sepsis was not quite certain, but Mr. Legg was inclined to the former view. He mentioned also that he had had a similar case in a younger woman who presented herself on account of having two or three round lumps in the substance of the tongue; each lump was elastic and about the size of a Barcelona nut. The patient volunteered the information that these lumps had been present some months before and had disappeared under treatment by iodide of potassium; there was no doubt that the lumps were multiple gummata. There was no glandular enlargement. In the course of a fortnight under iodide of potassium all that remained of the gummata was some slight thickening at the site of each of them. In this case, as there was no ulceration, no local treatment was adopted except keeping the mouth clean. Provided this is done in all cases, Mr. Legg pointed out, a very rapid improvement takes place. It was important, however, to impress on the patient the necessity of continuing the treatment after the local manifestations of the disease have disappeared. This treatment would consist in gradually dropping the mercury in those cases in which it had been administered and continuing the iodide of potassium for from three to six months.

OPERATING THEATRES.

ROYAL FREE HOSPITAL.

CASE OF CEREBRAL ABSCESS.—MR. JOSEPH CUNNING operated on a man, æt. 32, who had been admitted on account of severe headache, which had been going on for a week. For 10 years the patient had suffered from discharge from the left ear, which had ceased when the headache began. He had been under the care of his doctor during this time, and the night before the operation he had been sent to the hospital. On admission his temperature was 102, and although he had severe posterior headache, there was no tenderness over the region of the mastoid. The pulse was 100, and there were well-marked signs of chronic otitis media. On the morning of operation he developed further signs: slight drowsiness and a slow pulse rate varying from 64 to 74. There was no paralysis, but the left knee-jerk was considerably increased; other reflexes were apparently not altered. Before operating, Mr. Cunning remarked that there were distinct signs of increased intra-cranial pressure, as exemplified by the slow pulse rate, for in all other conditions, when a patient is as ill as this man, the pulse rate would be increased to 100 or over; next, the drowsiness was another symptom pointing to the same condition. The only other sign of pressure was the increase of the knee-jerk on the left side. As the patient was suffering from chronic otitis media, the present condition was, Mr. Cunning remarked, almost certainly a complication of that disease, and a collection of pus was probably what would be found. There was no evidence, however, as to the situation of the pus, whether it was in the cerebrum, cerebellum, or outside the dura mater. The eyes of the patient had been examined, and no optic neuritis had been found, but as this symptom was an unreliable one in respect to diagnosis, no great weight could be attached to its absence. Lateral nystagmus, which was usually a late symptom of pressure, was not present. He pointed out that, although there perhaps might seem insufficient reasons for

operating at this stage, yet those who had most experience of intra-cranial abscess knew that by the time the diagnosis has become easy and undoubted, the patient was generally beyond the reach of surgical aid. The patient was anæsthetised with chloroform by the house physician, Miss O. B. Smith, and Mr. Cunning pointed out that chloroform was the better anæsthetic for these cases, as it produced less congestion about the brain than ether, and he considered that the anæsthetic should be administered very lightly to this man on account of the risk of respiratory failure. He then said a few words about his plan of procedure, which was to begin by opening the mastoid antrum in the hope of discovering the direction taken by the pus; if no indication were found in the antrum or middle ear, then to trephine by separate openings so as to expose in turn the temporo-sphenoidal lobe and the cerebellum, these being the situations in which an abscess was most likely to be found. The mastoid antrum was then opened, and the bar of bone between the antrum and middle ear removed. It was then found that the tegmen tympani which formed the roof of the antrum was absent, having been destroyed by the disease. On passing a scoop through the opening thus left, a large abscess cavity, containing about two ounces of green and extremely fœtid pus, was entered and evacuated. Two drainage tubes were then put through this opening into the abscess cavity, which was then gently irrigated with saline solution. The ends of the tubes were then stitched to the lower part of the skin incision, dressings applied, and the patient sent back to bed. Mr. Cunning remarked on the wisdom of always exploring the antrum and middle ear to begin with. Though it was unusual for an abscess to be evacuated in this position, yet if one can do so, it undoubtedly was the best method, as the drainage of the abscess was through its most dependent part, and the surgeon has not to go through healthy brain-substance to reach it, as he would have to do by trephining. Another reason was that in a case with any serious complication of mastoid disease, thorough clearing out of the mastoid cavity must anyhow be effected, otherwise the patient would still be liable to further complications. He pointed out that it was always found that, in these cerebral abscesses, organisms (usually bacillus coli) producing a foul smell were present, as was exemplified in the present case. It was by no means certain, he thought, that the patient would eventually recover, although the abscess had been found and opened, as the pus sometimes extended to the descending horn of the ventricle even after the abscess had been evacuated.

It is satisfactory to state that a week after operation the man is free from headache, and able to sit up and talk to his friends. The drainage tubes are still in situ.

TRANSACTIONS OF SOCIETIES.

BRITISH GYNÆCOLOGICAL SOCIETY.

Meeting Held Thursday, October 12th, 1906.

Mr. F. Bowreman Jessett, President, in the Chair.

Dr. Macnaughton-Jones: Specimen of necrobiotic fibroid shown, and notes read by Dr. Harry Overy.

This tumour (shown) was removed from a patient æt. 39, and was accidentally discovered, as she never suffered from any pain or discharge, and her periods were regular and not excessive; she complained of feeling the abdomen distended and of passing urine with some difficulty. When I saw her the tumour distended the abdomen on the left side and reached to the umbilicus. On exposing the tumour, the protrusion at its left side was found to contain fluid which, on evacuation, proved to be disintegrated blood of a coffee-ground colour. The wall of the cavity was covered with soft semi-purulent exudation protruding into the cavity, evidently the necrobiosis had not been of recent occurrence. The central portion of the growth was very hard and thick, but nearer the necrobiotic cavity become œdematous. It would appear to me that infection did not reach from the uterine cavity, but that there had been a telangiectasis of portion of the tumour, and secondary breaking down of the tissue after hæmorrhage.

Dr. Cuthbert Lockyer examined the growth and reported that it was not malignant. The clinical history is interesting in the complete absence of any symptoms caused by the tumour, which must shortly have ruptured with probably a fatal issue. The patient made a complete recovery.

Dr. J H. Dauber: Specimen of necrobiotic fibroid, with notes. In July, 1905, saw a patient in consultation. She was æt. 40, single, and had been suffering acute pain for two or three years. Three weeks previously she had a sharp attack of pain while stooping over her housework, and had to take to bed. When he saw her the temperature was 101°, there was subacute peritonitis, and a tumour arising two or three inches above the umbilicus. On vaginal examination, another tumour was felt in Douglas's pouch. She was removed to the Hospital for Women, Soho Square, for operation. Upon opening the abdomen the tumour exhibited was found, which was a fibroid springing from the fundus of the uterus, with a twisted pedicle. There were many adhesions to the intestines, which were readily separated when the pedicle was transfixed and tied off. The uterus contained two or three fibroids, and was removed by supravaginal hysterectomy. The tumour was offensive, spongy, and dark, with contained blood. It would probably have become gangrenous, and caused the patient's death. It seemed to be a fibroid in which some change had taken place, such as twisting of the pedicle or infection from the bowel, and required immediate operation.

Dr. Heywood Smith understood there was some oozing in the case after operation, and wished to know whether any means were taken to stop it by adrenalin, and if drainage was used.

Dr. R. T. Smith proposed that Dr. Macnaughton-Jones' specimen should be referred to the Pathological Committee. It seemed to have been a very acute process, and there seemed to be nothing in the symptoms to account for it, such as rise of temperature, nor any indication of gross change. There may have been albuminuria to account for the lesion. In reference to Dr. Dauber's case, the symptoms exactly tallied with those of twisted pedicle in an ovarian tumour. It was very rare to have twisted pedicle associated with fibroid, or to see a fibroid with such a small pedicle.

Dr. W. H. Slimon seconded the proposition, which was agreed to.

The President said it was not uncommon for a pedunculated fibroid to get twisted. He thought most of the cases of gangrenous fibroid were due to calcareous change, interfering with the blood supply.

Dr. J. H. Dauber considered there might have been a twisted pedicle and consequent interference with the blood supply.

Dr. Harry Overy said he had noticed that in large fibroids hæmorrhage was found when examined microscopically. Whether the fibroid was pedunculated or not, the centre of the tumour showed early degeneration, even when to the naked eye it looked homogeneous throughout, and the microscope showed red blood-cells among the tissues in the centre.

Dr. J. H. Swanton said in Dr. Dauber's case there

was pyrexia and a history rather of gangrenous fibroid than necrobiotic. On section of a necrobiotic fibroid there was a soft liquefied centre which was caused by an infiltration of watery fluid, and more or less liquefaction of muscular fibres. In the specimen shown, there seemed to be no evidence of liquefaction having occurred.

Dr. J. H. DAUBER said the hæmorrhage was easily controlled, and he did not employ any drainage. He very rarely did drain, even in septic cases, and he had never had cause to regret it. He did not know the definition of necrobiosis was as narrow as stated. It was considered at the hospital to be a case in which necrobiotic changes had taken place.

The PRESIDENT showed a specimen from "A Case of Multiple Pedunculated Fibroid of the Uterus, with Calcareous Degeneration, removed by Cœliotomy and Enucleation of the Tumours" (which will be found in full on page 438 of the present issue).

Dr. F. A. PURCELL said he regarded the last case narrated as interesting, owing to the history of successful removal of the mammary glands some years previously being followed by calcareous degeneration in the fibroid tumours of the uterus.

Dr. HEYWOOD SMITH said the interest of this case consisted in the disease which arose in the uterus separated by ten years from the cancerous condition of the breast. He contended that the two diseases in this case were quite independent, but he was not sure that the fibrous condition of the uterus was not the primary cause of the mischief. One did not know how those fibroid tumours arose, but they were probably from uterine trouble. There were not sufficient cases to allow a generalisation, but the course of events seemed to be that the uterine irritation from the presence of the fibroid set up irritation in the breast, and from that carcinomatous degeneration arose. He believed there was no convection of the disease, but that the irritation took the form of cancer. He believed the fibroids occurred prior to the formation of cancer of the breast. The fibroids were small at first, and did not seem to have developed for many years afterwards.

Mr. HOWELL EVANS said one point of interest was the fact that the patient had malignant disease of the breast, and survived eight years. While possessing that condition of malignancy that there should be subsequently discovered a condition of natural protection in the way of calcification in a tumour which was recognised as being innocent. What was the state of that scirrhus of the breast? Was it one in which the fibroids and the calcareous tendency was extremely marked, and would consequently have given perhaps one of the rare occurrences of Nature's expulsion of a malignant tumour? If so, there was present an individual factor in a patient who showed a tendency to protection against malignancy. Apart from the question of any association with cancer of the breast, he had seen, in the practice of one or two gentlemen who had a great number of cases passing through their hands, three cases during the last three years of calcification of fibroids, and the small degree of symptoms was noteworthy. Unless they happened to be cervical or submucous, they had given rise to few symptoms. Was it possible to learn anything about the life history of fibroids from these calcifications? Patients came before the medical man at the age of 21 to 30, with symptoms which no gynæcologist was able to impute to fibroids. In five or ten years, or even longer, those patients might appear with a crop of fibroids, which more resembled the tuber of a potato than anything else. A fibroid might lie relatively dormant for many years, and then suddenly burst out, so that there was a crop of tumours. He asked whether any member of the Society could throw any light on the relation which bands of fibrosis or calcification in fibroids bore to the life history of fibroids.

Dr. J. H. DAUBER said he could see no relation between the carcinoma of the breast and fibroid disease of the uterus. It was common to find uterine carcinoma in conjunction with fibroids. With regard to calcification of fibroids, he had always looked upon calcification as a sign of the long duration of a fibroid.

Mr. CHARLES RYALL said the subject of enucleation of the tumours had always been a question of interest to him, as to when one should enucleate fibroid tumours of the uterus. There were some cases upon which enucleation should certainly be tried. In such cases as the President's, where there were calcareous fibroids, he regarded it as excellent treatment. Fibroids such as those just described had passed their days of growth and were undergoing calcareous degeneration. In his experience calcareous degeneration was not very common in fibroids. With regard to enucleation, there were certain cases of fibroid of the uterus in which he thought enucleation was desirable, cases where the condition of the fibroid somewhat approached calcareous degeneration—namely, where there were one or two hard fibroids of the uterus, especially in young women. He did not think it was justifiable to remove the uterus from a comparatively young woman where she had a very hard single fibroid. But where they were multiple, hysterectomy was certainly the proper treatment to carry out.

Dr. J. H. SWANTON wished to know the condition of the ovaries. In patients with calcified fibroids who submitted themselves to operation the chief symptoms complained of were pressure symptoms and uræmia, but otherwise there were very few symptoms. He would also like to hear about the mortality of the operation for the removal of fibroids, as Piquand's statistics of 175 cases showed a very high mortality compared with that of fibroids generally, namely, as much as 12%, against one of 3%-5%.

The PRESIDENT, in reply, said he had removed the ovaries on several occasions as a kind of last resort in cancer of the breast, but had not seen any improvement whatever follow. He had very little doubt that the fibroid in question had been of long duration, and only when it became calcified and pressed on the pelvic nerves, causing a radiating pain down the legs, was attention drawn to it. He agreed that the calcification of fibroids was an evidence of their long duration. He could not say whether calcification of the cancer in the breast was found. He had seen few calcified tumours of the uterus, and he was rather astonished to hear that Dr. Dauber had seen so many. With regard to enucleation, he agreed that generally it was bad practice to enucleate uterine fibroids, because there were probably more interstitial fibroids in the uterus than could be found on external examination. When subperitoneal calcified tumours were found at the age of this woman, he did not think there was any chance of further trouble, and therefore he enucleated them all. They came out easily, and there was no difficulty with hæmorrhage. In some of the deeply seated interstitial fibroids of the uterus there was considerable difficulty in stopping the hæmorrage. The ovaries were small, but quite healthy, and were not removed. He had very little doubt that if this woman's fibroids had not become calcified she probably would not have been troubled with any pain whatever. He could not say what was the mortality after operation in these cases, as he had not a sufficient number of cases on which to form an opinion.

The PRESIDENT then showed a specimen from "A Case of Severe Menorrhagia with Retroversion of Uterus and Intramural Fibroid in Fundus. Vaginal Hysterectomy" (which will be found on page 439 of the present issue). He said that in connection with this there was another specimen which he removed a week later, and was interesting, because he doubted the diagnosis. The patient was a woman æt. 36, who had had a miscarriage about two months before coming in, and she had had constant hæmorrhage more or less ever since. When she was admitted she had a foul-smelling discharge coming from the uterus. On passing the sound into the uterus, hæmorrhage was very free. He formed the opinion in that case that

she had carcinoma of the fundus, so he removed the uterus, and had brought it up for inspection. She made a good recovery. The pathologist informed him that it was a piece of placenta.

Dr. R. T. Smith desired to know whether the President would have removed the uterus if he found the growth on examining with the sound, or used a snare after dilatation.

Mr. Howell Evans said with regard to the question of menorrhagia, that he agreed with the President in saying that when the menorrhagia was marked there seemed to be little short of hysterectomy to relieve the condition. There was a true scientific treatment of all cases of menorrhagia. One observed the patient for a short time and might adopt a palliative method, but the point was to recognise not by the quantity lost alone, but by the condition of anæmia. If the patient at each successive period lost more blood than she ought to, as shown by the blood count in the intermenstrual period, that patient was losing ground, and the more she lost ground the less use she had for an organ which had an abnormal and irregular function, and one had to decide between removal of that organ as a useless organ and the preservation of the individual as a useful member of society.

Prof. R. J. Kinkead (Galway) said he thought the last speaker had gone too far. He had in his mind half a dozen cases in which there was marked menorrhagia, continuing for a long time, and in some of which, when they came into hospital under his care, they were in a condition of profound anæmia. One case showed the difficulty of diagnosing submucous fibroids. She was over 56, and he curetted her four times. He examined the uterine cavity with his finger, but could find no evidence of fibroid at all. She came in again suffering from menorrhagia. He then dilated the cervix uteri, and on that occasion he found a polypus which he could touch. He removed it with an écraseur, and found it to be the size of a goose egg. It must have extruded since he operated before. She was now healthy and resumed her ordinary occupation. He had recently had under care a series of cases of persistent menorrhagia for which he felt he could have done nothing. There was nothing wrong except that there was a natural want of contractile power. Curetting was of no use. But he found that by steadily applying iodine and phenol to the inside of the uterus the patient recovered. The last case was that of a woman who had been married twelve months and had miscarried. She was sent to the hospital from the Union. He went to the hospital a few hours after her arrival, and the hæmorrhage was more profuse than he had ever seen before. He had to plug the uterus, but she was now perfectly well, after treatment with iodised phenol twice a week for two months to the uterine cavity. He opposed removal of the uterus for hæmorrhage in all cases.

Dr. C. H. Bennett said he had had a considerable experience of menorrhagia, but he had not heard a word that evening with regard to treatment of it in the shape of medicine. All that had been discussed had been operation. He had had some bad cases of menorrhagia which had been considerably relieved and eventually stopped by giving 10-grain doses of gallic acid. Under that treatment the cases had soon got very much better, and the flow had eventually ceased altogether. If he had another case of the kind he would try that before suggesting any operation, unless of course it was clear that there was some fibroid or polypus present to cause the bleeding.

Dr. F. A. Purcell pointed out that the medical side of the matter was not being discussed. It was the common practice to treat cases of menorrhagia by other means before deciding to operate; such things as sulphide of calcium or tincture of hydrastis or the tincture of any astringent were employed.

Mr. C. Ryall remarked that it was notoriously easy to be wise after the event, but on looking at the specimen as brought forward, it seemed to be more a matter for dilating the cervix than for hysterectomy. It looked as if it could have been enucleated and the organ put back again. The first and most important treatment for the condition was rest. The patient might be put to bed and given all sorts of drugs, but it was the rest which did the good. Where reasonable treatment was carried out and was found to be of no avail, and where no tumour could be detected, the organ was functionally useless, and not only so, but it was a source of danger.

The President, in reply, said it was impossible to get a snare round it. It was submucous, and more or less interstitial.

The President, continuing, said it was a very large uterus, about three and a half inches in length. The top of the uterus could not be reached, and therefore it could not be ascertained whether it was a submucous fibroid or a fibroid at all. At all events, the finger could be introduced far enough in to make sure that there was no polyp. If that could have been found the polyp would have been removed and the uterus saved. But he thought the result would probably warrant what he did. She was a poor woman, with seven children, and the living of those seven children depended upon her efforts, as she was a widow. It was true he might have given her a pint or two of gallic acid and kept her in bed, a treatment which might have stopped the hæmorrhage, but his impression was that all the gallic acid in the world would not stop it, because she still had the fibroid, and she would have lost the chance of getting her living and that of her children. Therefore he contended it was far better to get rid of a useless organ, and allow the woman to have a chance of recovering her health and strength, than to delay for months with the bare chance of doing her good. He fell in with the remarks expressed by Professor Kinkead, and he had not only used iodised phenol, but had found fuming nitric acid more useful. If one dilated the uterus in some of the cases of simple endometritis with general thickening of the mucous membrane, then by curetting and applying fuming nitric acid, relief would follow. It was a more beneficial treatment than the application of iodised phenol. It was necessary to pack the vagina with carbonate of soda solution to prevent burning of the vagina. But the patients had no pain afterwards. It caused no discomfort. But in such a case as that now under discussion, where no cause for the condition could be ascertained, the treatment was to remove the uterus.

The President then read the notes of "A Case of a Large Abscess in Douglas's pouch simulating a suppurating Ovarian Cyst causing Bowel Obstruction." (This is published in full on page 439 of present issue.)

Dr. Smallwood Savage took it that a case which definitely showed pus in the pelvis should be opened per vaginam. But there was a certain class of case in which it was most difficult to diagnose pus, either acute salpingitis or a case of extra-uterine gestation. The operation in either of those cases would necessarily be by the abdominal route. He did not think he could follow the President when he said he did not think the vaginal operation would have been successful. He thought probably it would, because pus would always follow the line of least resistance, and if one had made a line of least resistance by doing a posterior vaginal cœliotomy, one would be producing a track which the pus would follow and come down by the vagina, except for that which collected in little pockets.

The President, in reply, said he was still in doubt as to the origin of this pus. But the history pointed to appendicitis. Four months ago she had severe pain and vomiting. Five weeks before operation she had severe abdominal pain and vomiting, which lasted for twenty-four hours. With regard to opening the vagina, he did not think those pockets in the abdomen would have discharged into the vagina. About a week after the operation she had a sudden rush of pus through the abdominal wound, probably from another pocket of pus. He was very much

afraid of pulling the intestines about, because he thought that if he did he would make the patient's condition very much worse.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

MEETING HELD THURSDAY, OCTOBER 16TH, 1906.

PRIESTLY SMITH, F.R.C.S., President, in the Chair.

MR. GEORGE COATS read a paper on

POSTERIOR SCLERITIS, AND INFARCTION OF THE POSTERIOR CILIARY ARTERIES.

He referred to the first description of this condition by Fuchs in 1902, and to cases probably similar reported by Knapp, Wagemann and Salzer. Only two such cases had been submitted to pathological examination. In his own case the disease was not diagnosed during life, as the eye when first seen was already disorganised by iridocyclitis.

On dividing the globe, a peculiar round area 10 mm. in diameter was found above the papilla, in the form of a brown island, surrounded by a broad yellow moat or gutter. Within this area, the inner third of the sclera, and the whole thickness of the choroid and retina were completely necrotic. There was no inflammatory thickening of the necrotic patch, but a moderate round cell infiltration of the living tissues. The other changes in the eye were due to iridocyclitis and secondary glaucoma.

Mr. Coats pointed out that the amount of necrosis was out of all proportion to the inflammation, so that there must have been vascular obstruction. The necrosis was more extensive in the retina than in the choroid, and in the choroid than in the sclera, and this corresponded to the usual wedge shape of the infarction. The affected area would correspond to the distribution of one of the larger posterior ciliary vessels, and these vessels had but scanty anastomosis with each other. The changes in the retina were closely similar to those found in the rabbit after ligature of the ciliary arteries, and in man after optico-ciliary neurotomy. The surrounding chronic inflammation was similar to that found in non-infective infarctions elsewhere, and the chronic iridocyclitis was probably of the same nature, due to the diffusion of toxines of low virulence into the vitreous. There was some evidence of vascular obstruction in two of the other reported cases.

MR. HOLMES SPICER read a paper on

METASTATIC AFFECTIONS OF THE EYE.

The first case was that of a young man who had a sudden attack of pain in one eye, with obliteration of the central part of the field of vision. He was in good general health, except for a large crop of boils on the buttocks from rowing at Cambridge. On examination of the eye three days after the attack of pain, a brilliant green mass was seen springing from the centre of the disc; it was round, sharply defined, and had no appearance of structure, such as hooklets. Its appearance suggested a parasitic cyst. It continued to grow, and was making the patient very ill. It was lacerated with a needle under ophthalmoscopic guidance, but it only contained some cloudy opaque material like pus. The eye was enucleated.

The swelling was found to be an abscess in the substance of the retina, having in its centre a large mass of staphylococci. The patient made a rapid recovery in health.

The second case was also that of a young man, who had had a large boil on the neck, and was suddenly seized with pain in one eye, with loss of sight. He had well-marked phlebitis of the retinal arteries in one eye and slightly in the other. After prolonged treatment one eye got well, and the other became quiet with loss of sight. Two years later it became acutely inflamed and was then enucleated. Although very seriously ill at the time, he recovered promptly after removal of the eye, showing it to be the only part affected.

The third case was also that of a young man, who had retinal phlebitis, followed by local keratitis profunda after a serious attack of diarrhœa and ptomaine poisoning.

The fourth case was one of diffuse exudation on the surface of the choroid, invading slowly nearly the whole of it and producing in places detachment of the retina. This also occurred in a young man suffering from a large crop of boils on the neck. Treatment by anti-staphylococcal injections was commenced, but he refused to continue it.

DR. EDRIDGE-GREEN read a paper on

OBSERVATIONS ON HUE PERCEPTION.

These observations were made with an instrument by means of which the exact size of a portion of the spectrum which appeared monochromatic was ascertained, when it was isolated from the adjacent portions. Hue perception was found to be most accurate in the blue and yellow regions, though in most it was more accurate in the yellow region. Then there was a gradual diminution towards the centre and ends of the spectrum. Green came next, then violet, and lastly red. These facts were in accordance with the author's theory of colour perception, and were predicted by it, namely that the colour perception of different individuals varies with the development of a colour-perceiving centre in the brain, that those with a greater development of this centre see more colours (points of difference) than those with a less development, and that colours appear in a regular order at the successive points of difference in a straight series.

HARVEIAN SOCIETY OF LONDON.

MEETING HELD OCTOBER 11TH, 1906.

DR. ALEXANDER MORISON read a paper on the

CARDIO-VASCULAR STATE IN ASPHYXIA NEONATORUM, AND ITS MANAGEMENT.

He adopted the usual classification of these cases into the cyanotic and pale varieties, regarding the latter as a more advanced stage of the former, and proceeded to discuss the underlying physiological and pathological conditions in the two varieties.

In discussing prognosis he regarded the condition of cardiac action as the best guide to a forecast, and stated that asphyxia under these circumstances represented the etymological origin of this term—namely, *pulselessness*, the prognosis being favourable in proportion to the vigour of cardiac action. The more remote consequences of asphyxia neonatorum were then discussed, and he considered that many of the certified causes of death in early infancy, such as hæmorrhage, atrophy, convulsions, and atelectasis, bore a direct relation to asphyxia neonatorum.

In considering treatment he discussed the question of dividing or not dividing the funis immediately after the birth of the child, and stated that only in the cyanotic variety was it advisable to allow the funis to bleed for a short time. He then considered the methods of artificial respiration, and remarked that recent anatomical investigation and physiological conceptions of cardiac action justified a prolonged effort to resuscitate the stillborn infant, as pulsation of the auricles might continue after the heart had ceased to be heard beating, and might provoke ventricular contraction even after the case appeared to be hopeless from general signs.

DR. LONGRIDGE stated that at Queen Charlotte's Hospital they considered that the "blue" baby and the "white" baby resulted from totally different conditions. The former was the result of asphyxia, and the proper treatment was to clear out the pharynx and perform artificial respiration. The latter was due to shock, and pulsation in the cord was usually absent. The proper treatment was a hot bath, gentle stimulation, and massage of the heart. Artificial respiration was unsuitable.

MR. T. HERBERT HERRING then read a paper on

EASY METHODS OF STERILISING URETHRAL INSTRUMENTS,

giving a practical demonstration of the methods. He considered that cystitis was most commonly due to

the employment of septic catheters or bougies. The use of a catheter was entrusted to anyone, the instruments were often not efficiently sterilised, the lubricant more especially was a frequent cause of sepsis as usually applied, and efficient cleansing of the operator's hands was neglected. He had therefore devised a method of sterilisation of catheters by which both the catheter and lubricant were sterilised, and little manipulation of the catheter by the operator was required. The catheter, or series of catheters, were suspended from hooks in a cylindrical metal vessel containing water and a small quantity of vaseline. The water was then brought to the boil by a spirit lamp underneath, and the catheter sterilised, and when withdrawn was coated with a thin layer of sterilised vaseline. If catheters were wanted some time after sterilisation, they could be placed separately in glass tubes and sterilised in the same way, each glass tube being corked up with a sterilised rubber plug after withdrawal from the steriliser. He showed a number of ingenious contrivances of a similar nature for sterilising one or more catheters very rapidly, and also a sterile lubricated catheter in a hermetically sealed case which could be carried about ready for use.

Mr. Raymond Johnson had found the method of boiling water and oil in a test-tube for sterilisation and lubrication of a catheter efficient, but the boiling oil tended to roughen the catheter.

Mr. Daniel had also used this method, but had much greater success with Mr. Herring's steriliser, which he had used for some time. He had not had an instance of cystitis after this method of catheterisation.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

Meeting at the Medical Institution, Liverpool, Friday, October 19th.

Mr. R. Favell (Sheffield), President, in the Chair.

Dr. A. W. Lea (Manchester) showed a specimen consisting of a portion of skin from just below the umbilicus with a fistulous trail extending from it to the ovary. The whole was removed by abdominal section.

Dr. Lloyd Roberts (Manchester) showed a specimen of carcinoma of the clitoris, the third case he had seen within a few months. Also a complete specimen of ruptured ectopic gestation of about three months' growth.

Dr. Walter (Manchester) showed a uterus removed from a single woman, æt. 27, with a sub-peritoneal myoma which occupied the broad ligament. This required special treatment, and was bunched up and sutured in several places to avoid the formation of a hæmatoma. The uterus also contained a small fibroid undergoing cystic degeneration.

Dr. W. Blair Bell (Liverpool) mentioned two cases of fibromyomata which presented interesting complications.

Dr. W. F. Shaw (Manchester) read a paper on

Chorea of Pregnancy

illustrated with 11 cases which had occurred in the practice of St. Mary's Hospital, Manchester, during the last fifteen months. The first two cases were treated on traditional lines, given nourishing diet, arsenic, salicylates, and finally abortion induced, with the very worst results; both mothers died and also both children. The succeeding nine cases were treated on the supposition that their condition was due to a toxæmia; they were kept strictly in bed, their diet consisted solely of milk, and elimination was increased by acting on the bowels, skin, and kidneys with purgatives, diaphoretics, and diuretics. Thyroid extract was given to five patients without any definite result. Under the treatment every mother recovered, and all the children were born alive except one which could not be resuscitated, although the fœtal heart was heard a little time before delivery. Only four patients gave a history of previous chorea, or rheumatism; the remaining seven had histories of shock or worry, though two of these were doubtful. Nine patients were primiparæ, one had one previous pregnancy with chorea; the remaining patient had had two previous pregnancies without any chorea.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Oct. 21st, 1906.

Chronic Leucæmia.

Leucæmia is characterised by an enormous and progressive increase in the number of the white corpuscles of the blood, and can be observed under two principal forms: *lymphogene* leucæmia, characterised by the increase of the non-granular mononuclears, and a decrease in the red corpuscles and the polynuclears; *myelogene* leucæmia, with increase of all the granular leucocytes, and especially the myelocytes, and decrease of the red corpuscles. Leucæmia can be either acute or chronic, but the former is rare.

A patient suffering from chronic leucæmia gets gradually weak and thin, while the skin becomes of almost livid pallor. These general signs are frequently to be observed at the very outset of the affection, but in many cases they are preceded by some local but very characteristic signs. Generally the patients complain of a sensation of tension, weight, and even of pain in the left hypochondriac region, or of gastric troubles, such as tedious digestion and tympanism. In some cases abundant gastric hæmorrhage or recurring epistaxis aggravate the already pronounced anæmia. On examination hypertrophy of the spleen is found, with which is associated sooner or later other signs, as tumefaction of certain superficial glands, chiefly the sub-maxillary. Later on new glands are affected, constituting chains, which ultimately fuse into one hard mass. Sometimes these signs are wanting or are little apparent; the pallor and the frequent tendency to hæmorrhage are the principal troubles which guide the medical attendant to seek for more special physical signs. The glands, the spleen, and the liver should be carefully explored. Although the cervical ganglions may not be attacked, those of the axillary, inguinal, iliac, and popliteal regions should be examined—they are frequently found hypertrophied. The increase in volume of the spleen is one of the most habitual signs of leucæmia. At the very outset of the disease the spleen is increased in volume, passing below the false ribs and invading all the left hypochondrium; to the touch it seems smooth and regular. It increases in size progressively, and finally fills up the left iliac fossa, provoking digestive troubles and difficulty in the respiration.

Hypertrophy of the liver is frequent, but not to the same extent as that of the spleen.

Other symptoms may exist, such as anorexia, vomiting, diarrhœa, cutaneous lesions (eczema), priapism from thrombus of the cavernous body, pains in the spine, the sternum, or the long bones, retinitis (one-fourth of the cases) œdema of the extremities, phosphaturia, increase of uric acid. The patient falls into a state of cachexia, fever sets in, and death supervenes from marasmus. The duration of the malady is from one to two years, but the end may be hastened by an attack of hæmorrhage.

Acute Leucæmia.

Parmentier resumes the essential clinical features as follows:—The début is brusque but variable in its symptomatic expression. One patient, perfectly healthy, is suddenly seized with abundant epistaxis, slight rigors, headache and prostration, and enters the hospital with all signs of purpuric infection. Another presents fever, cutaneous hæmorrhage, ulcerative stomatitis, which in a few days determines gangrene of the gums, of the cheeks, and the lower lip. In a third

the affection commences insidiously by great prostration, with dyspnœa soon followed by an eruption of purpura, tumefaction, and bleeding of the gums.

Sometimes acute leucæmia manifests itself by pains in the joints and erythema, easily mistaken for acute rheumatism, or by œdema of the face or a sensation of debility, with pain in the region of the spleen.

The cutaneous hæmorrhage sets in early, the skin is covered with purpuric spots, the gums and the mucous membrane of the mouth are swollen and bleed easily, and finally become covered with ulcers.

The patients are profoundly anæmic, as is witnessed by the general debility, the pallor of the skin, vertigo, and palpitations. The tumefaction of the liver, the spleen, the glands, are much less pronounced than in the chronic form, or may be entirely absent. The uric acid in the urine is enormously increased, while albuminuria is constant. The malady may run its course in three or four days, but it never exceeds eight or ten months, and is always fatal.

CYSTALGIA.

The following will be found of great service in treatment :—

Bromide of camphor, 2 grs.
Ext. of valerian, q.s.
Per one pill. Four daily.

Tincture of thurga accidentalis, 10 grams.
Ten drops three times a day.

Chloroform, 2 dr.
Ether, 3 dr.
Spirits of camphor, iv grs.
To rub on the lumbar region twice a day.

GERMANY.

Berlin, Oct. 21st, 1906

AT the Naturforscherversamnilung Oberstabsarzt, Bieck spoke on the supervision of the soldier. Perhaps nothing that has yet occurred has shown the value of such supervision as the late Russo-Japanese War, in which intelligent care of the soldier practically added many thousands of seasoned men to the ranks of one of the contending armies. Dr. Bieck recognises that in European armies also more attention must be paid to the health of the fighting man. Military surgeons, he says, should show activity in barracks, on parade grounds, on the march, supervising the healthy man, and should use their hygienic knowledge for the maintenance of the soldier's health. He, and not the officer, should arrange the bill of fare, and should care for the needful dietetic changes, and say what is and what is not suitable. Wheat bread in its turn is urgently needful. In the canteen the soldier should be able to procure what fills up the deficiencies of the ordinary diet. He should be able to buy fat, lard, bacon, good country butter, or at least margarine that is above suspicion, albumen in the form of herrings or thin cheese, cakes, and fruit or vegetables. The beer should be nourishing and cheap, and spirits should be forbidden altogether. The surgeon must visit the canteen often and unexpectedly. The greatest cleanliness must be observed in the living and sleeping rooms and in the latrines. The "Kommissgeruch" must disappear. Frequent bathing—a daily bath or at least a daily douche. In summer, in connection with bathing in the open air, there should be sun baths, gymnastic exercises, the soldier being unclothed, or at most having only bathing drawers on. On the parade ground the surgeon should observe which men the exercise tells on, and which quickly get out of breath. He must further note the weak ones, and those with inherited or other tendencies to disease. He must not rely on the weaklings being brought before him. Early dismissal of men who are not able to fulfil the military requirements often prevents life-long invalidism. On every long march a surgeon should accompany the troops as the counsellor of the officer in command. He must give advice as to suitable clothing, and on the choice of material his word should be decisive. Sunstroke will not cease until the present clothing is changed. In summer, instead of woollen, it should be linen, drill, or khaki. In summer, also, the foot-covering should be lighter than in winter; half-wool or cotton socks; thin shoes or sandals in place of heavy boots. Sweaty feet and blisters might be avoided in this way. In the surgeon the soldier should see the benevolent adviser rather than the superior officer. The soldier cannot choose his doctor, and for this reason the doctor ought to strive to gain the men's confidence and trust.

SCOPOMORPHINE.

Under this name a preparation has been brought out by Riedel, Berlin, intended to play a part in producing anæsthesia. It is a compound of hydrobromide of scopolamine and hydrochlorate of morphia. It is claimed that hydrobromide of scopolamine has certain definite properties and produces a definite effect without any disagreeable or unwished-for by-effect. The intention is to employ it for producing total anæsthesia (scopolamine-morphia narcosis of Korff). The patient is to be prepared beforehand. The bowels must be opened and the teeth and buccal cavity, if possible, kept in order 24 hours before employment. During this period easily-digested liquid food should be given, and an hour before the anæsthetic a quarter of a litre (8 ozs.) of milk tea, milk coffee, or strong broth. (It should be stated that the preparation is sold in sterilised ampullæ.) One-third of an ampulla should be injected two and a half to three hours before the operation, a second third one and a half hours before, and the last about three-quarters of an hour before. The anæsthesia is completed by ether spray or minute quantities of ether or chloroform. After the first painful skin incision but little of these latter anæsthetics will be required—perhaps none at all. From the time of the first injection the room should be kept dark and absolutely quiet.

After the operation the patient should be left at rest to enjoy the full benefit of the anæsthetic. When he begins to waken he may have some Fachingen or Vichy Celestine water in teaspoonful doses, and after about six hours a cup of broth or milk tea.

For what is called half-anæsthesia for obstetric cases, etc., half the above-named doses are given.

It is also used as an analgesic and sedative for the calming down of excitement and the relief of pain, as in inoperable carcinoma and tabes, for instance. Here one-sixth, one-quarter, or a half of an ampulla may be given once or more times daily. The general employment of scopolamine has hitherto failed, as is known, owing to the impossibility of manufacturing the alkaloid in a sufficiently pure and stable form. Now success has been attained in this direction, it is expected to come into more general use.

THE HANDLING OF FOODS.

Dr. Cohn, of Charlottenburg, in the *Med. Reform*, calls the attention of the police to the unnecessary and uncleanly custom of touching nearly all sorts of foods with the hands of the server at the time of selling. In selling sweets, for instance, the hands of the man, woman, or girl, whether clean or unclean, are thrust into the receptacle containing them. A handful is taken out and put on the scales. If too many, the surplus is put back into the receptacle, to be handled at least once more before they leave the premises. Sweets, one remembers, go directly, without cooking or other preparation, into the mouth, with all their imperfections on them, whatever they may be. But, as the *Deutsch. Med. Zeit.* points out, there are shops *and* shops, and the would-be buyer need not buy if he sees any mis-handling of the food-stuff he was intending to purchase. Education will mend these and many other matters in time, and the public itself may hasten the process almost as fast as it likes if it will only take trouble to do so.

AUSTRIA.

Vienna, Oct. 21st, 1906.

DISEASE IN THE LARGE INTESTINE.

SVEHLA drew attention, at the Prague meeting, to several diseases in the mucous membrane of the large intestine that simulated other diseases, or, rather, the symptoms lead the clinician astray in his diagnosis. A simple hyperæmia was often so severe in its

symptoms as to lead to the belief in a rupture; while others give rise to such localised pain in the extremities as arouses the suspicion of coxitis. Irritation of the large intestines will produce spermatorrhœa, and lead to the erroneous diagnosis of gonorrhœa.

His method of treating such intestinal troubles was to give a patient a sitz bath three times a day, or after every motion if the bowels move often, and treat the large intestine with 2 per cent. cocaine ointment of vaseline. The bowel should be brought into a loose condition as soon as possible, and cocaine suppositories used, containing 0.01 of a gramme = .15 of a grain each. Five to seven days is the usual duration of such treatment in very severe cases.

Xanthoma Tuberosum.

Brandweiner showed a boy, 5 years old, with large tubercles in the cutaneous surface, which were examined histologically and found to contain all the characteristics of xanthoma tuberosum, which confirmed the clinical diagnosis.

The peculiarity of this case lay in the absence of diabetes and icterus, both or either of which are usually associated with the disease. The boy was brought to the clinic suffering from diphtheria, from which he recovered, leaving the xanthoma.

Umbilical Hernia.

Escherich exhibited a six weeks' child with a hernia that had existed from the fourth day after birth. When admitted, the swelling was about the size of a hen's egg, with a very wide base, unfitting it for surgical operation. A dry powder was used over the ulcerating navel cord, which gave off an offensive odour. The temperature continued high for some time, but ultimately fell, followed by healthy granulation, which he hopes will finally heal without further interference.

Epidemic Cerebro-Spinal Meningitis.

Semerad reported the case of a 13-year-old girl who appeared to suffer from cerebro-spinal meningitis, but the attack was so slight that a bacteriological examination of the cerebro-spinal fluid was necessary to confirm the diagnosis by the presence of the meningococci. After eight days she began to recover for a short period, but the fever began to intermit, with severe pain in the head and occasional jerking, which extended down the neck, with slight paresis down the left side of the face, associated with vomiting. The fluid from the cerebro-spinal membranes was again examined, and found normal. After this she became rapidly worse, becoming unconscious, with paralysis of the right side of the face, right extremities, with involuntary emissions of fæces and urine, and high fever. Shortly after this, all these symptoms disappeared, and the patient recovered, leaving aphasia and deafness as the sequelæ, which we cannot clearly explain. The deafness seems to be improving, but the aphasia remains stationary.

Rhinoscleroma.

Mesicek and Guttmann demonstrated a case of this disease. Frankenburger raised a discussion on the locality—the north-east of Bohemia—where this patient had come from, which was a centre of the disease. He advocated isolation and medical control of the neighbourhood. Finally, a commission was formed by the Society to undertake the examination and report on the subject.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Royal Infirmary, Edinburgh.—At their last meeting the managers made the following appointments to the staff of the institution:—Dr. Harry Rainy, to be assistant physician, vice Dr. Philip, promoted to be full physician; Dr. John S. Fraser, to be assistant surgeon in the Ear and Throat Department; and Dr. R. C. Low to be assistant physician for diseases of the skin.

The Professor of Physiology, University of Glasgow.—Dr. Noel Paton was entertained at dinner by a numerous company of his Edinburgh friends on the 16th inst., prior to his taking up his duties in Glasgow. The function took place in the hall of the Royal College of Physicians, and was presided over by Sir John Batty Tuke, M.P., the croupiers being Dr. John Playfair and Mr. C. W. Macgillivray, the presidents of the two Royal colleges. Dr. G. A. Gilson proposed Dr. Paton's health in felicitous terms, and after replying Professor Noel Paton proposed "The Edinburgh School," to which Professor Cunningham replied. The toast of "The Glasgow School" was given by Professor Schaefer, and responded to by Professor Stockman. Professor Paton took up his new duties on the 19th, when he was formally introduced by Professor Stockman, Dean of the medical faculty, and delivered his inaugural lecture. After paying a tribute to his two predecessors, Professors Andrew Buchanan and McKendrick, he defined the purpose of the medical profession as a great organisation to prevent, rather than cure, disease. The reason why they were not more successful was want of knowledge. Magnificent as their victories had been in fighting cholera, diphtheria, and tuberculosis, the territory compassed was small in comparison with that still unsubdued. Cancer remained, but when they obtained, as they must, knowledge of its nature, it would become as preventible as cholera. The public, however, must take a share in their quest, and give it moral and material support. The medical profession knew, and they must see that the public also knew, that for the advancement of medicine and surgery experiments on the lower animals were required.

Opening of the Winter Session.—The winter session opened in Edinburgh on the 16th. A new departure in the systematic teaching of medicine has been made in the extra-mural school. Three of the most popular teachers, instead of each conducting a separate course of lectures, have combined their forces, and will now give a conjoined series of a hundred lectures, in which each will deal with the department of medicine over which he has especial mastery. The idea is quite revolutionary, as nothing of the kind has hitherto been attempted. If we are to judge by the numbers of students who are attending the combined class it will be as successful as it is novel, and one may predict that Drs. G. A. Gilson, Bruce, and Philip will have not a few imitators in the other branches of medicine within a very few years.

Opening of the New Physical and Engineering Departments, University of Edinburgh.—These new departments, which have been constructed on the site of the old fever hospital, the buildings of which have been to a great extent utilised in the process, were formally opened on the 16th by Dr. Andrew Carnegie, on whom at the same time the degree of LL.D. was conferred. Mr. Carnegie's address took the form of a plea for science teaching, and a protest against the classical tradition and outworn philosophy and metaphysics. He condemned the retention of Greek as a necessary preliminary to obtaining a degree at Cambridge, and rejoiced that the Chancellor (Mr. A. J. Balfour) had travelled to that university to vote against it. Mr. Carnegie also gently satirised two of his hearers (Mr. Balfour and Mr. Haldane) who, he said, "found recreation from the high affairs of State searching for the foundations which are never found, or for the pathway to reality, proving to the satisfaction of readers that there is about the pathway no reality whatever." Subsequently Mr. Balfour in his turn, in acknowledging the debt which the University owed to Mr. Carnegie and Lord Elgin, poked a little mild fun at Mr. Carnegie, who, he said, began with a broadside which certainly demolished the Chancellor of the University, the Lord Rector, the Professors of Ancient Languages, the Professors of Divinity, and the Professors of Philosophy. But all Scotsmen, he said, had the taint of metaphysics in their blood, and Mr. Carnegie's Scotch blood was too much for him.

Diphtheria Epidemic in Paisley.—On account of the prevalence of diphtheria it has been found necessary to close all the Board schools, and most of the other schools in the town. About 12,000 children are affected by the closing order.

BELFAST.

THE WORKHOUSE SANATORIUM.—At the last meeting of the Board of Guardians, the question of a permanent medical staff for the new sanatorium was discussed, and it was decided to appoint a visiting medical officer and two residents, the senior at £150 per annum, and the junior at a lower rate. The senior will be required to hold office for at least a year. The mode of appointment for the visiting officer has not yet been decided.

PUBLIC HEALTH.—On October 16th, a deputation from the Belfast Citizens' Association waited on the Chief Secretary in Dublin with reference to the general health of the city. The deputation was a large and influential one, comprising men of all shades of political and religious opinions. It was introduced by Sir Charles Brett, and its objects were clearly stated by Professor Byers and Dr. Calwell. They dealt with the high death-rate of the city, the alarming amount of preventable disease, specially typhoid and phthisis, and the questions of milk supply, infantile mortality, and hygiene in elementary schools. Other speakers who followed drew attention to the failure of the authorities to comply with the obligations incurred under the Act of 1889 dealing with the sewage question, with the evils of jerry-built houses on filled-in land, and other causes of bad health in the city.

Mr. Bryce gave a most sympathetic reply, and explained in what way the various points could best be dealt with. A Royal Commission could only be obtained by Act of Parliament if it was to take evidence on oath. The Local Government Board had certain powers not yet exercised in Belfast, which might meet the case. He asked for a written statement of the case put before him by the deputation, and promised it every attention.

On the following day, October 17th, a deputation from the Public Health Committee of the Corporation waited on Mr. Bryce with regard to the necessity for re-introducing into Parliament the Public Health Bill, which was brought in last year and dropped. The sudden zeal of this Committee, following so closely on the deputation from the Citizens' Association, is hardly likely to escape Mr. Bryce's notice, and no doubt will afford him some amusement.

BELFAST CHRISTIAN CIVIC UNION.—Under the auspices of this Society, a two-day Conference was held in Belfast last week, the opening meeting being presided over by her Excellency the Countess of Aberdeen. The Union is a new society, the objects of which are to purify city life and induce men to realise that good citizenship is an essential part of good Christianity. It has already obtained widespread and influential support, and will no doubt prove a power for good in the affairs of the city. The papers read dealt with such subjects as street betting, temperance, the employment of children, charity organisation, infant mortality, and so on. An admirable address was delivered by Professor Byers, who took as his subject "Infantile Mortality, Child Insurance, and Cleanliness." The infantile mortality in England, he said, was about 145 per 1,000—that is, that of every 1,000 children born 145 died in their first year. In Ireland generally it was little over 100, but in Irish towns it was about the same as in England, and in Belfast it was 150 for the past six years.

LETTERS TO THE EDITOR.

"DIRECT REPRESENTATION" ON THE GENERAL MEDICAL COUNCIL.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I had decided to withdraw my name from the list of applicants for the election of three direct representatives on the General Medical Council, and this decision has been mentioned in the *British Medical Journal* for October 6. The advice of professional friends, on whose judgment on this matter I rely more than on my own, has induced me to reconsider the question, and I now beg to offer myself as a representative of the profession on the General Medical Council.

For thirteen years previous to 1888 I was a general practitioner at Hartlepool, and as medical officer to large clubs and friendly societies, and Medical Officer of Health to the Borough and in private practice also, I obtained an extended experience of the requirements of ordinary everyday practice and practitioners.

For the last five years I have been President of the Northumberland Medical Association, now merged with the North of England Branch of the British Medical Association, and known as the Northumberland Committee. Its functions are limited to the advancement of the interests of its members directly, and indirectly of the medical profession in Northumberland. The work that has been done by us here, especially in increasing the fees for contract practice has satisfied me that, if we know what we want and the whole profession co-operates in any reasonable demand, it will not, because it cannot, be refused.

There is one point on which I must offer a strong opinion. It has been urged that only those in practice as general practitioners should be appointed to fill the vacancies on the General Medical Council. It seems difficult to believe that this view can be held by any but a minority of the 20,000 voters on whom the result depends unless the invaluable services rendered by Sir Victor Horsley can be left out of consideration. In this part of the country we derived very great advantage from the help and co-operation of consultants, and I feel strongly that to divide the profession into independent sections can only end in disaster. The co-operation of all is needful if any real and permanent improvement in the conditions of medical practice is to be obtained. I am acquainted with the work that has been done by the General Medical Council of late years, and am fully in sympathy with the efforts that have been made to suppress disreputable forms of practice. Without, however, a new Medical Act passed on the lines adopted by the British Medical Association, I am of opinion that the chief evils from which the profession now undoubtedly suffers cannot be satisfactorily dealt with.

I am, Sir, yours truly,

RUTHERFORD MORISON.

Saville Row, Newcastle-on-Tyne.

MOTOR-CARS AND DUST.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The letter of your correspondent, "A London Physician," is more suggestive than perhaps he intended it to prove. It explains to the reflective observer why the medical profession in England exerts so little influence on ordinary public opinion. Why does "A London Physician" look for an authority to "One of our highest-class newspapers"? The question of mofor-cars and dust concerns the student of hygiene; what can the editor of even a distinguished lay paper know of the matter. Instead of quoting the opinion of the journalist in question, "A London Physician" should rather have assumed the right and the duty of questioning the validity of the criticism. In answer to the familiar charge that the motor-omnibus is "noisy," why did he not state that this purely relative defect is being rapidly remedied by improved machinery? In reply to the trivial accusation of objectionable "smell," why did he not remark that it is a mere matter of temporarily defective respiration (*i.e.* carburation)? To remove the reproach of "ugliness" why could he not invoke the tyranny of evolution which forces the motor-car to resemble an antiquated stage-coach? And lastly, why did he not use the opportunity in meeting the incrimination of "dangerous" to deliver an instructive lecture on the growing complexity of our higher reflex nervous action?

How many journalists know that the horse is the host of the bacillus of lockjaw (tetanus)? How many have ever heard bacteriologists ask themselves whether the dust in the street, contaminated from the same source, is not one of the causes of the fatal summer diarrhœa of children? When I was a student at Middlesex Hos-

pital I remember Mr. Walter Lang often remarking in the out-patient department on a windy day: "We will soon have the usual series of cases of inflamed eyes." And his prediction was invariably verified. That was a time when the newspapers deplored the prevalence, owing to the ignorance of the population, of infective ophthalmia in Egypt!

"A London Physician" should read M. Clemenceau's recent speech at Draguignan. It should, in the first place, have a superficial interest for him. For the speaker resembles your correspondent in being a medical man, but differs from him in using a motor-car! And it should have, on a deeper study, an animating influence upon him, for the powerful and fascinating orator would show him what medicine and medical men are doing for a socially aspiring France. M. Clemenceau informed his audience that the new subordinate departments of hygiene and social science are already forming the elements of a ministry in the future. I am afraid that this coming ministry would scarcely seek for inspiration in the view of "A London Physician."

I am, Sir, yours truly,
A. W. Gilchrist, M.D.

Nice, October 20th, 1906.

THE SUPPRESSION OF QUACKERY.

To the Editor of The Medical Press and Circular.

Sir,—In one of your recent leaders deploring the backsliding of *The Times* in publishing quack puffs of the sort formerly denounced by its editors, you remarked that the probable result might be that inferior papers would now "go one worse" than the erstwhile leading journal. Your prophecy has unfortunately turned out to be correct. I send a copy of a country paper in my locality in which appear two puffs of the cruel kind which promise cure of organic disease by medicines. Formerly all puffs in this paper were marked conspicuously "advt."; these puffs are printed in every respect like editorial matter, and will no doubt drive simple readers into the hands of the quacks. If the proprietor of this paper were appealed to he would no doubt reply that not only *The Times* but all the leading newspapers do the same. How could he be expected to take a higher stand than the proprietors of *The Times*, or the noblemen who own great London dailies—*The Telegraph*, *The Daily Mail*, and *The Morning Post*—and who have made their position and their wealth through this property.

I am, Sir, yours truly,
Surrey, Oct. 20th, 1906. S.

OBITUARY.

JAMES FINLAYSON, M.D., LL.D., L.R.C.S.

Death has robbed Glasgow of one of the leading ornaments of its medical school in the person of Dr. James Finlayson. His name and fame have reached far beyond the bounds of the city in which he practised, and are household words South of the Tweed and in the British Colonies. Born in 1840 in Glasgow, and educated at the High School of his native city, Dr. Finlayson began his college career as an arts student at the early age of sixteen. But he soon turned out into the world, and earned his living in business for five years before taking up medical study in 1863. After a distinguished university career, he graduated M.B. with honours in 1867, and at the same time took the L.R.C.S.Edin. After serving as house physician at Manchester, and as assistant to Sir William Gairdner at the Glasgow Royal Infirmary, he was appointed physician to the Western Infirmary in 1875. In 1883 when the Glasgow Sick Children's Hospital was opened, he was elected physician, and in this post he served till 1898, when he was made consulting physician. As a clinical teacher, Dr. Finlayson was widely and deeply appreciated, as his classes abundantly testified, whilst as a consultant he was in great request. His opinion was always worth having, and none who called him in a difficult case ever failed to glean something from his peculiarly sagacious and well-balanced mind. But Dr. Finlayson's fame will not die with him, for he was the author of perhaps more books and papers than any man in the profession. No less than sixty contributions he made to the *Glasgow Medical Journal*, twenty or more to the *British Medical Journal*, and just ten to the New York *Archives of Pediatrics*. His taste for medical literature was evinced by his holding for twenty-five years the post of librarian to the Faculty of Physicians and Surgeons of Glasgow, an institution of which he was particularly fond, and of which he became successively vice-president and president. Finlayson's *Clinical Manual* is known the world over by students. In America, under the title of "Clinical Diagrams," two large editions were speedily exhausted soon after publication. Of his other works a mere list would extend to two columns, but we cannot forbear to mention particularly his erudite contributions to the history of medicine. Dr. Finlayson was performing his usual professional duties on the 8th of this month, when he was taken suddenly ill. His death, which took place on the 10th, came as a great shock and grief to all those associated with him.

FREDERICK HURST CRADDOCK, M.A. Cantab., M.R.C.S. Eng.

We regret to announce the death of Mr. Frederick Hurst Craddock, medical superintendent of the Gloucestershire County Asylum, who was found dead in his bedroom at his residence at Wotton, Gloucester, yesterday. He was fifty-five years of age, and had occupied the post for twenty-four years. For a long period deceased suffered from heart affection. His medical education was carried out at St. Bartholomew's Hospital Medical School, whence he took the diploma of the English College of Surgeons in 1877. His loss will be greatly felt in the county.

Dr. TOM WALKER.

By the recent death of Dr. Tom Walker, announced yesterday, the medical profession in Manchester has lost a man of brilliant parts and promise. At the age of twenty-eight he determined to leave the work of a schoolmaster and to enter upon the study of medicine, having in the meantime taken his B.Sc. at the London University. He entered the Medical School at Owen's College, where he was the first holder of the Professor Tom Jones Memorial Surgical Scholarship, of the value of £100. At the time of his death he had just passed the 37th year of his age.

LIEUT-COL. CALEB WILLS, C.B., L.R.C.S.I. L.R.C.P.I.

Lieut.-Col. Caleb Shera Wills, C.B., died at his residence, Lunecliffe, Lancaster, on Friday night, after a lingering illness, aged seventy-two years. He took part in the Zulu War in 1879, being senior medical officer at the base of operations, and of the line of communications between Durban and the Lower Tugela, and received a medal and C.B. for his services. Deceased qualified in 1861.

FRANK LESLIE PHILLIPS, M.D. Brux., M.R.C.S. Eng.

We regret to notice the death of Dr. Leslie Phillips at the comparatively early age of forty-nine years. For many years deceased devoted himself to dermatology, and had consulting rooms in London and in Birmingham. During the past few years, however, he lived at Leamington, and practically retired from practice. He was educated principally at Queen's College, Birmingham, and at the London Hospital. He took the diploma of the English College of Surgeons in 1882, and the M.D. of Brussels in 1883. He was closely associated with the late Mr. Lawson Tait in the Medical Defence Union, but later seceded from that body and was one of the founders of another similar association. For many years he held the post of surgeon to the Birmingham Hospital for Skin and Urinary Diseases.

SPECIAL ARTICLE.

REPORT OF THE IRISH PRISONS BOARD.

THE Report of the General Prisons Board, Ireland, for the year 1905 (*a*) shows that Ireland remains in a fairly satisfactory condition as regards crime. The daily average number of prisoners, 2,601, in 1905, was almost identical with that in the previous year, 2,570. The proportion of the daily average number of prisoners to the total population has remained practically stationary for several years; but it is to be noticed that the number of convicts has shown during the past ten years a very remarkable decrease. In 1896 the average daily number of convicts in Irish prisons was 395; last year it was 238, showing a diminution in that period of 39 per cent.

One hundred and ninety-six juveniles (*i.e.*, under 16 years of age) were committed during the year. Of these, 31 were either discharged or remained untried, and 165 were convicted. Of the latter, 100 were sentenced to short terms of imprisonment; 29 were discharged under the Summary Jurisdiction over Children Act, or under the Probation of First Offenders Act; 30 were sent to reformatories or industrial schools; and 5 were bound over to keep the peace. It is satisfactory that the number of juveniles committed shows a marked decrease during the past ten years, no less than 343 having been committed in 1897. It is remarkable that no less than 12 children under 12 years of age were committed to prison during the year. It is significant that, of these, 4 committals came from one Bench. Regarding the imprisonment of children of tender age, the Prisons Board make the following remarks:—

"We cannot too strongly express our regret that children of from 9 to 11 years of age are still sent to prison by some magistrates, as the above table shows, for such offences as throwing stones into a harbour or in the street, loitering at a harbour or near goods, or trespassing in pursuit of game. Although the common objection to sending children to gaol—viz., the allegation that they 'herd with common criminals'—is absolutely untrue, the practice is deplorable on other grounds. They become for life branded with the prison taint, and being well and kindly treated, lose the salutary dread of prison of which they acquire no experience in its severer disciplinary aspect. All juvenile prisoners are located in a part of the prison entirely by themselves, and have no intercourse whatever with adult prisoners. Those under sentence of a month's imprisonment and upwards are sent to Mountjoy Prison, Dublin, for special reformatory treatment. A considerable amount of time is devoted to school, gardening, and physical drill. They are also taught some useful industry, at which they work in their cells with doors open under the supervision of specially selected officers."

With regard to the health of prisoners, the Report states:—

"The health of the prisoners has been good. There was very little zymotic disease except influenza; there was no case of either typhus or typhoid fever.

"Among local prisoners there were, excluding an execution, 5 deaths. Two were the result of cardiac syncope in constitutions debilitated by drink, 1 was caused by valvular heart disease, 1 by delirium tremens, and 1 from sudden failure of the heart's action. There were 2 deaths in the convict prisons, 1 from paralysis, and 1 from angina pectoris. From local prisons 31 were released on medical grounds before the expiration of their sentences, and one from the convict prisons. Of these, 11 were women who were near their confinement.

"Sixty-four insane prisoners were transferred from local prisons to lunatic asylums. Out of this number 52 were insane on reception, 5 had been ordered to be detained during the pleasure of the Lord Lieutenant as having been insane at the time of committing the offence, or being incapable of pleading, and of the remaining 7, 1 was weak-minded, 1 was an epileptic, and 1 had been an asylum inmate. Two insane convicts were transferred to Dundrum Criminal Lunatic Asylum; 1 of them had always been weak-minded."

It is satisfactory to learn that during the past 13 years corporal punishment has only been administered twice. It is never now inflicted except for mutiny, incitement to mutiny, or gross personal violence to an officer or servant of the prison.

The Board express regret that at only one prison has advantage been taken by Visiting Committees of the power given to them under the new rules introduced in 1902 to organise lectures for prisoners—*i.e.*, at Dundalk Prison, where the series of lectures delivered in the year 1904-5 was followed by another lecture, the subject of which was "Temperance and Hygiene," on October 8th, 1905.

In the prisons generally there is an increase in industrial employments for the prisoners.

In Ireland there is one State Reformatory for Inebriates, situated at Ennis, and during the year 10 persons were committed to it. As five years have now elapsed since habitual drunkards began to be discharged from Ennis, the Board is able to afford some information with regard to the effects of the treatment. During the five years, 63 persons have been discharged; of these, 5 are dead, 3 in lunatic asylums, 4 re-committed, 21 relapsed, 27 doing well, and 3 whose after-history is unknown. This record is certainly not unsatisfactory, but nevertheless the Board hope for better results if the committals were earlier and the sentences longer.

The Report as a whole furnishes much interesting reading, and its arrangement is more simple than that of most Government publications.

(*a*) "Seventy-eighth Report of the General Prisons Board, Ireland." With an Appendix. Dublin: Printed for His Majesty's Stationery Office by Alexander Thorn and Co. 1906. Price, 8½d.

LITERARY NOTES.

THE October number of the *Westminster Review* contains a statistical and well-reasoned article on the "Progress of Insanity in Our Own Time," by Mr. W. J. Corbet, in which he shows the increase of insane in this country in a decade to have reached the terrible proportions of 25,000.

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THERE is an amusing satire in a recent issue of the *World*, by Oakley Williams, introducing its readers, in dialogue form, to two recognised types of medical men, under the heading "Bedside Manners." Lady Ethel Chloride is suffering, or imagines she is suffering, from indigestion and a cold in the head; she wants an excuse for getting her husband to take her to Egypt to spend the winter. Dr. Jones, a young man of distinguished academic career, who has recently started in private practice, enters, and after the customary questioning, tells the patient honestly, although in scarcely polite professional language, that there is nothing seriously the matter with her—nothing, in fact, that cannot be readily cured with a little walking exercise and a dose of simple medicine. Exit Dr. Jones, the patient being soon after visited by Dr. Lequaque Smith, of irreproachable get-up and suave to breaking point. He has been strongly recommended by a lady friend, and tells her her case is one of great scientific interest, frightens her by talking of the antrum of Highmore, the Eustachian tube, and the vermiform appendix, and, finding his cue, suggests she should spend the winter in Cairo after his treatment—limited to two visits per diem for three weeks—and retires, conscious of having secured a wealthy patient, and she delighted at the discovery of a man who exactly understands her constitution.

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WE have received from the *News of the World* office a book of over 200 pages, entitled "Medicine for the Million." It is written by a family physician, and contains a large amount of useful information arranged under alphabetical headings. Many terms are used,

however, which are too technical for the lay reader, and actual prescriptions should have been entirely omitted from a book such as this. The price is 1s. net.

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Among British health resorts, Bath, Buxton, Harrogate, and Matlock, stand pre-eminent. Of their claims to the consideration of the medical profession when it becomes, as it necessarily does daily, a question of the suitability of one or the other for their patients' particular needs, it is not our purpose here to speak. Before us lies a gorgeously-illustrated guide-book, entitled "Harrogate for Health and Pleasure," written and compiled by Hy. J. Buckland, and published by the corporation of Harrogate. If anything in the nature of beautiful pictures could attract, nothing better than this book would be necessary for the purpose. But this health resort has more than its picturesque surroundings to recommend it; its bathing establishment is probably the most perfect in Great Britain, its hotel accommodation unique, and the comfort and amusement of its visitors are as well catered for as at the most favoured resort on the Continent. All this is described and illustrated in the book before us, which we understand is sent free to members of the profession on application.

THE NEW PRESIDENT OF THE ROYAL COLLEGE OF PHYSICIANS OF IRELAND.

We reproduce above a portrait of the newly-elected President of the Royal College of Physicians of Ireland. Dr. J. M. Redmond is well-known and is most popular in Irish medical circles. He obtained the Licence of his College in 1878, the Membership in 1881, the Fellowship in 1884, and in 1901 and 1902 he served as Vice-President. He holds the posts of Visiting Physician to the Mater Misericordiæ Hospital, and of Consulting Physician to the Coombe Lying-in Hospital and St. Michael's Hospital, Kingstown. He has made numerous contributions to medical literature both in these columns and in those of our contemporaries.

REVIEWS OF BOOKS.

THE TREATMENT OF GONORRHOEA. (*a*)

The terseness of the author's style makes this book pleasant reading, besides the evidence acquired during its perusal that Mr. Leedham-Greene knows what he is talking about, and that, whilst shunning the realms of theory so often invaded by writers on venereal diseases, he is eminently practical. The first two chapters are devoted to "Some Important Details Concerning the Anatomy of the Urethra and Bladder," and here the author rather shatters the theory of Professor Finger, that the bladder when distended becomes pear-shaped owing to the formation of a "bladder neck" through the yielding of the internal prostatic sphincter. Mr. Leedham-Greene shows by his own experiments that the distended organ is oval, the outline of the urethra in the radiograph being sharply cut off from the bladder with a suggestion of a "bladder neck." He lays also great stress on the separation of the urethra into anterior and posterior by the compressor urethræ. After describing acute anterior and acute posterior urethritis and devoting two interesting chapters to the bacteriology of, and the morbid changes in, the urethral secretion, he enters upon the treatment of (*a*) anterior urethritis, and (*b*) posterior urethritis, pinning his faith to the proper use of injections; the ideal remedy being (1) one that is able rapidly to destroy or remove the virus, the gonococcus; (2) one that does this without injuring the mucous membrane; (3) one that allays the existing inflammation. With reference to chronic urethritis, Mr. Leedham-Greene is of opinion that the frequency with which the prostate is involved is greatly underestimated. The chapters on chronic urethritis and its treatment are very interesting with regard to the pathology, diagnosis, &c.; unfortunately, however, bearing in mind the title of the book, we were disappointed in finding nothing new in the *treatment* of this most rebellious affection, most reliance being placed on Diday's and Janet's methods when only the mucous membrane is affected, and rational and systematic dilatation with bougies or dilators in cases where the inflammation has penetrated deeply into the tissues. We were all the more disappointed as, after having read the author's preface, we were prepared to be startled by some fresh and boldly thought out methods of treatment (made in Germany) to guide English surgeons in their struggle with urethral discharges. Part II. is devoted to the Complications of Gonorrhœa, with a chapter on Gonorrhœal Metastases. The last chapter is excellent, and deals with a very difficult subject, "The Proof of the Cure of Gonorrhœa." Among other dicta in this part of the book the following words should be treasured by all surgeons:—"In treating gonorrhœa, as, in fact, all diseases, the patient must be considered as well as the disorder. We must be careful lest in our anxiety to eradicate the last vestige of inflammation we unduly prolong the treatment, and by centering the patient's thoughts too much on his trouble, we induce serious neurasthenia and hypochondriasis.

The formal opening of the Brussels School of Tropical Medicine took place last week. The school has been founded by King Leopold, and will work in conjunction with the similar establishments of London and Liverpool.

The medical officer for Bermondsey reported to the last weekly meeting of the Council that scarlet fever was excessively prevalent in the borough. The cases were scattered fairly evenly over the whole district, and there was no common cause discoverable, such as milk, school infection, &c. The disease was of a very mild type, so much so that many children were going about with the rash fully developed.

(*a*) "The Treatment of Gonorrhœa in the Male." By Charles Leedham-Greene, M.B., F.R.C.S. Pp. xii., 151, with 36 illustrations. London: Bailliere, Tindall and Cox. Price 5s. net.

MEDICAL NEWS IN BRIEF.

Royal College of Surgeons of Edinburgh.

AT the Annual Meeting, held on the 17th inst., the following office-bearers were elected for the ensuing year:—

President.—Charles Watson MacGillivray, M.D.

Vice-President.—Sir Patrick Heron Watson, M.D., LL.D.

Secretary and Treasurer.—Robert M'Kenzie Johnston, M.D.

Librarian.—Henry Alexis Thomson, M.D.

President's Council.—Joseph Bell, James Dunsmure, Joseph M. Cotterill, Francis M. Caird, George A. Berry, James W. B. Hodsdon. *Ex-Officio*, The Vice-President, the Secretary and Treasurer, the Representatives on the General Medical Council.

Representatives on the General Medical Council.—James William Beeman Hodsdon, M.D.

Examiners.—John Smith, Joseph Bell, Alexander G. Miller, George Hunter, James Dunsmure, Charles E. Underhill, Sir John Halliday Croom, James Ritchie, William Craig, Charles W. MacGillivray, Joseph M. Cotterill, James Hunter, Charles W. Cathcart, Francis M. Caird, George A. Berry, James W. B. Hodsdon, James Maxwell Ross, Robert M'Kenzie Johnston, Robert H. Blaikie, Robert A. Lundie, Russell E. Wood, George Mackay, Junr., David Wallace, Henry Alexis Thomson, Kenneth M. Douglas, Harold J. Stiles, William George Sym, Henry Harvey Littlejohn, Alexander Miles, Arthur Logan Turner, William Guy, James Musgrove, John W. Dowden, Frederick M. Graham, Archibald A. Scot Skirving, James Veitch Paterson, Theodore Shennan, David Waterston, Nathaniel T. Brewis, James Haig Ferguson, R. Stewart MacDougall, Thomas W. Drinkwater, George H. Gemmell, James Kerr, Cargill G. Knott, Duncan MacDonald.

Public Health Examiners.—James O. Affleck, William Craig, James Maxwell Ross, Henry Harvey Littlejohn, Alexander Buchan, George H. Gemmell, J. Falconer King, Cargill G. Knott.

Dental Examiners.—John Smith, Joseph Bell, William Craig, Robert A. Lundie, William Guy, Archibald A. Scot Skirving, George W. Watson, Frederick J. Turnbull.

Assessors to Examiners.—Sir Henry D. Littlejohn, Sir Patrick Heron Watson, John Smith, John Chiene.

Conservator of Museum.—Henry Wade, M.B.

Clerk.—James Robertson, Solicitor.

Auditor of Accounts.—George H. Carphin, C.A.

Officer.—Clarendon Hyde Creswell.

Assistant to Conservator.—George Reid.

Dr. Jowett's New Appointment.

Dr. H. A. D. Jowett, who has just been appointed Manager of Works of Burroughs Wellcome and Co., acted as chief research chemist under Dr. F. B. Power in the Wellcome Chemical Research Laboratories, and during his ten years' connection with these laboratories he conducted a number of important investigations, notably on the chemistry of the jaborandi alkaloids, the constituents of cascara, etc. Dr. Jowett has distinguished himself at every step of his career. A Bell Scholar in 1891, he passed the Minor and Major Examinations of the Pharmaceutical Society, and secured the Pereira Medal and Redwood Scholarship in 1892. The following year he graduated as B.Sc. London. Between 1894 and 1896 he acted as Assistant Lecturer in Chemistry to the Pharmaceutical Society and Demonstrator in its Research Laboratories, and in 1896 took his degree of Doctor of Science at the London University. His exceptionally brilliant scientific work is well known through papers read before the learned societies, and his contributions to scientific journals. His researches in regard to the active principles of aconitine and jaborandi are classical, and he has contributed largely to our knowledge of effective methods of drug standardisation. During the present year he has been elected a Member of Council of the Chemical Society.

Royal Commission on Trinity College and the University of Dublin.

This Commission has been sitting daily in the Board Room of Trinity College. The sittings are private. During the past week the witnesses called before it have principally consisted of the Provost, Fellows, and Professors of the University. Medical witnesses were called for the first time on Saturday, when Professors A. C. O'Sulivan, M.D., A. F. Dixon, M.B., and W. H. Thompson, M.D., were examined. The Royal Commission have intimated their willingness to receive from persons who have not already submitted their views on the matters in question any objections or criticism which they may desire to submit for the consideration of the Commission, in regard to the schemes, suggesting changes in the constitution and government of the College and the University, which are contained in the appendix to their first report. It is necessary that such statements of objections or criticisms should be brief, and that they should reach the Secretary of the Commission, 16, Ely Place, Dublin, not later than November 1st.

Convocation of the Royal University of Ireland.

The following have been elected members of the Annual Committee for the coming year:—Walter E. Adeney, D.Sc.; S. Lombard Browne, M.A., K.C.; John J. Charles, M.A., M.D., M.Ch., D.Sc.; Denis J. Coffey, M.A., M.B., B.Ch., B.A.O.; John Donaldson, M.A.; Daniel S. Doyle, LL.B.; Francis T. Heuston, M.D., M.Ch.; Christopher Joynt, M.D., Surgeon-General; John C. M'Walter, M.A.; Edward J. M'Weeney, M.A., M.D., M.Ch., M.A.O.; Edward Magennis, M.D.; James C. Meredith, M.A.; Joseph F. O'Carroll, M.D., M.Ch.; John Park, M.A., D.Lit.; Joseph P. Pye, M.D., M.Ch., D.Sc.; Alfred J. Smith, M.B., M.Ch., M.A.O.; Sir Thornley Stoker, M.D., M.Ch.; Andrew Todd, M.A., LL.D.

PASS LIST.

Royal College of Surgeons in Ireland.

The winter session commenced on Monday, October 15th, when the following prizes of the previous session were distributed by Mr. H. R. Swanzy, President of the college.

Barker Anatomical Prize.—£31 10s., P. G. M. Elvery.

Carmichael Scholarship.—£15, C. Greer.

Gold and Silver Medals in Operative Surgery.—Gold, D. Adams. Silver: R. M. Bronté.

Stoney Memorial Gold Medal in Anatomy.—G. S. Levis.

Descriptive Anatomy.—Junior—W. A. Swan, First Prize (£2) and Medal; A. A. Pelissier, Second Prize (£1) and Certificate. Senior—G. C. Sneyd, First Prize (£2) and Medal; I. Scher, Second Prize (£1) and Certificate.

Practical Anatomy.—First Year—H. D. Gasteen, First Prize (£2) and Medal; H. G. P. Armitage, Second Prize (£1) and Certificate. Second Year—H. J. Hedley, First Prize (£2) and Medal; Miss I. M. Clarke, Second Prize (£1) and Certificate.

Practice of Medicine.—H. W. White, First Prize (£2) and Medal; D. Adams, Second Prize (£1) and Certificate.

Surgery.—H. W. White, First Prize (£2) and Medal; T. Sheehy, Second Prize (£1) and Certificate.

Midwifery.—H. C. Carden, First Prize (£2) and

Medal; W. E. M. Hitchins and T. Sheehy (equal), Second Prize (£1) and Certificate.

Physiology.—H. J. Hedley, First Prize (£2) and Medal; J. Menton, Second Prize (£1) and Certificate.

Chemistry.—J. J. Lyons, First Prize (£2) and Medal; R. White, Second Prize (£1) and Certificate.

Pathology.—H. F. Kay, First Prize (£2) and Medal; G. S. Levis, Second Prize (£1) and Certificate.

Physics.—R. White, First Prize (£2) and Medal; R. H. Weir, Second Prize (£1) and Certificate.

Practical Histology.—R. Adams, First Prize (£2) and Medal; O. W. J. Wynne, Second Prize (£1) and Certificate.

Practical Chemistry.—J. J. Lyons and P. I. Wigoder (equal), First Prize (£2) and Medal.

Public Health and Forensic Medicine.—T. C. Boyd and C. T. Cullimore (equal), First Prize (£2) and Medal.

Materia Medica.—J. J. Lyons, First Prize (£2) and Medal; H. W. White, Second Prize (£1) and Certificate.

Biology.—H. D. Gasteen, First Prize (£2) and Medal; J. S. Pegum, Second Prize (£1) and Certificate.

The Royal University of Ireland.

The following candidates have passed the undermentioned examinations:—

The M.D. Degree Examination.—Michael Cagney, M.B., B.Ch., B.A.O.; Charles G. Lowry, M.B., B.Ch., B.A.O.; Isabella G. A. Ovenden, B.A., M.B., B.Ch., B.A.O.; Frederick W. Stewart, B.A., M.B., B.Ch., B.A.O.; John J. Wallace, M.B., B.Ch., B.A.O.

The M.Ch. Degree Examination.—Samuel T. Irwin, B.A., M.B., B.Ch., B.A.O.

The M.B., B.Ch., B.A.O. Degrees Examination.—*Upper Pass.*—Francis X. J. Callaghan; John L. Dunlop, B.A.; James R. Hackett, Robert F. Kennedy, Patrick T. McArdle, Robert M'Crea, A.M.L., Charles B. Pearson, Percy B. Ridge, Maria Rowan, Thomas Tobin, James Warnock, M.A.

Pass.—Charles D. Bell, Samuel Bradbury, Harry L. Bristow, Holden Carson, John Dowling, John Dunlop, Patrick J. Dwyer, Edward Fitzgerald, James J. A. Gannon, James Gaston, Mary E. Jeremy, B.A., Charles G. Knight, Samuel W. Kyle, Morgan Lane, Samuel McCormac, William T. McCutcheon, Daniel McGrath, Jeannie R. Murray, Joseph A. O'Halloran, B.A., Maurice A. Power, William B. Purdon, Charles H. G. Ross, Maurice P. Scanlon, James M. Warnock, Ernest F. Watson, Thomas West.

The following candidates may present themselves for the further examination for Honours in the Groups set after their names:—Francis X. J. Callaghan, Medicine; John L. Dunlop, Medicine, Surgery; Robert F. Kennedy, Surgery; Patrick T. McArdle, Surgery; Robert McCrea, A.M.L., Surgery; Charles B. Pearson, Medicine, Surgery, Midwifery; Maria Rowan, Medicine; James Warnock, M.A., Medicine, Surgery, Midwifery.

Diploma in Mental Diseases. — Frederick W. Stewart, BA., M.B., B.Ch., B.A.O., Queen's College, Belfast.

Royal Academy of Medicine.

The annual general meeting of the Royal Academy of Medicine in Ireland was held in the Royal College of Physicians of Ireland on October 12th. Dr. J. Magee Finny was elected President, for three years, in place of Sir Thornley Stoker.

The following officers were elected for the ensuing year:—

General Secretary—James Craig, M.D., Secretary for Foreign Correspondence, Sir J. W. Moore, M.D. Medical Section—President, the President R.C.P.; J. B. Coleman, W. R. Dawson, H. C. Drury, T. P. C. Kirkpatrick, A. R. Parsons, G. Peacocke, F. C. Purser, W. Langford Symes, W. J. Thompson, W. A. Winter. Surgical Section—President, the President R.C.S.; C. A. Ball, Alex. Blayney, Sir A. Chance, T. E. Gordon, W. S. Haughton, G. J. Johnston, J. Lentaigne, R. C. B. Maunsell, E. H. Taylor, W. Taylor.' Obstetrical Section—President, R. D. Purefoy; Paul Carton, Gibbon FitzGibbon, R. H. Fleming, A. J. Horne, H. Jellett, F. W. Kidd, Sir A. V. Macan, A. J. Smith, Sir W. J. Smyly, E. H. Tweedy. Pathological Section—President, J. F. O'Carroll; A. H. Benson, J. B. Coleman, H. C. Earl, L. G. Gunn, E. J. M'Weeney, H. C. Mooney, T. G. Moorhead, A. R. Parsons, J. A. Scott, A. H. White. Section of Anatomy and Physiology—President, A. F. Dixon; D. J. Coffey, A. Fraser, H. M. Johnston, E. P. M'Loughlin, J. Alfred Scott, W. H. Thompson. Section of State Medicine—President, F. C. Martley; A. E. Boyd, T. P. C. Kirkpatrick, E. J. M'Weeney, J. A. Matson, Sir John Moore, W. A. Winter.

Royal Colleges of Physicians and of Surgeons.

Conjoint Examinations in Ireland — First Professional Examination.—Cadidates have passed this examination as under-noted:—H. E. Clarke, J. Devine, H. D. Gasteen, J. Gormley, J. J. Glynn, J. D. Hamilton, E. E. Holden, R. H. Hodges, W. V. Johnston, A. P. Kennedy, A. M. A. Lanphier, L. A. Moran, W. H. Murray, H. M'Adee, J. M'Mullan, T. B. Newman, M. A. O'Callaghan, B. O'Donnell, J. H. O'Neill, J. Purcell, A. Wiley.

Second Professional Examination.—W. S. Coffey, F. J. Colgan, J. Donoghue, D. J. Harty, J. Healy, J. T. Heffernan, L. C. Johnston, J. Marmion, J. J. O'Connell, M. C. O'Hara, W. Rahilly, L. C. Rorke, W. F. Russell, I. Schor, R. S. White. Copies of the preliminary regulations for 1907 can be obtained on application.

Royal College of Physicians of Edinburgh, Royal College of Surgeons of Edinburgh, and Faculty of Physicians and Surgeons of Glasgow.

The following candidates having passed the requisite examinations of the Conjoint Board during October, were admitted Diplomates in Public Health:—Edward M. Nicholl, M.D., Edin.; David M. Mathieson, M.B., Ch.B., Edin.; Laurence W. Pole, M.B., Ch.B., Edin.; William H. Hill, M.D., Kelso; William Darling, M.B., F.R.C.S.E., Edin.; Hugh A. Stewart, M.B., Ch.B., Pitlochry; Murdoch Macdonald, M.D., Shettleston; Katherine J. S. Clark, M.B., Ch.B., Edin.; Edward Valenzia, M.B., Ch.B., Edin.; Henry M. Sauzier, M.B., Ch.B., Edin.; Thomas Scoresby-Jackson, M.B., Ch.B., Walthamstow; Edward P. Calder, M.B., Ch.B., Coldingham; Francis E. Larkins, M.B., Ch.B., Edin.; and Jamshyd D. Munsiff, F.R.C.S.E., Portobello.

The following passed the First Examination in Public Health:—Francis P. Lauder, Cap., R.A.M.C.; Ferniehirst H. Borthwick, M.B., Ch.B., Edin.; Sohrab Hodiwalla, L.R.C.P. & S.E.Edin., and Thomas R. Smith, M.B., Ch.B., Edin.

Royal College of Surgeons of Edinburgh.

The following candidates, having passed the requisite examinations, were at a meeting of the College, held on the 17th inst., admitted ordinary Fellows:—John R. Askew, L.R.C.S.E., Fochabers; William L. Bennett, M.B., Ch.B., Capt. R.A.M.C.; Bertram M. Bone, M.B., C.M., Marske-by-Sea; Devereux Gwynne-Hughes, L.R.C.S.E., Sydney; H. Astley Knight, M.B., L.R.C.S.E., Lieut., I.M.S.; Charles D. Lochrane, M.B., Ch.B., Glasg.; Arthur L. Lynch, M.D., C.M., Ottawa; George B. McKean, M.B., M.R.C.S. Eng.; Belfast; Maxwell MacKelvie, M.B., Ch.B., Capt. I.M.S.; Edward J. Morton, M.B., Ch.B., Edin.; Frederick G. Twigg, M.R.C.S. Eng., Rotheram; and John H. Yearsley, L.R.C.S.E., Edin.

The medal and set of books presented to the College by Colonel William Lorimer Bathgate, in memory of his late father, William McPhune Bathgate, F.R.C.S.E., Lecturer on Materia Medica in the Extra-Academical School, was awarded after the usual competitive written examination in Materia Medica, &c., to John Joseph O'Sullivan, 31, Warrender Park Terrace, Edinburgh.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS. ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT GYNÆCOLOGICAL AND OBSTETRICAL LITERATURE.

Endometritis Atrophica Purulenta Fœtida.—Broese (*Zeitsch. für Geb. u. Gyn.*, Bd. LVIII., Hft. 1) records his observations on two women, aged 65 and 67 years, who had passed the menopause by 18 and 21 years respectively, and who had been suffering for many months from a profuse, purulent, and extremely foul discharge. One patient complained, in addition, that she had cramp-like pains every day in the lower part of the abdomen, and in the discharge shreds of friable material were found. There was no hæmorrhage in either case. Since the purulent matter was certainly coming from the uterine cavity, cancer of the body of the uterus was immediately suspected. Microscopical examination of the curettage showed no evidence of cancer in either case. The tissue removed from the first case looked like an abscess membrane. That removed in the second showed an advanced interstitial endometritis with disappearance of the glandular tissue in some places. The packing of the uterus with iodoform gauze after the curetting improved the condition very materially in both cases. The application of chloride of zinc and antiseptic intra-uterine douches were also found useful. G.

Pyelonephritis in Pregnancy.—Ruppaurer (*Münchener med Wochensch*, 1906, Nr. 6) observed ten cases of this complication of pregnancy within two years. Infection may come either through the blood or through the urine. The bacillus coli plays the most important part. The author's experience coincides with that of Opitz, that during pregnancy by far the most frequent path of infection is upwards from the bladder. Pressure on the ureter by the pregnant uterus, and the consequent damming back of the urine is an especial predisposing cause (the compression pyelitis of pregnancy of Sippel). The disease is more frequent on the right side. It generally makes its appearance during the middle months of pregnancy, and its onset is usually sudden, with rather severe symptoms. The clinical picture is that of the so-called urinary sepsis. The quantity of the urine is at first lessened, but later it is often increased, and its condition is fairly characteristic. Tenderness on pressure is usually found in the region of the right kidney, and there may be also pain on pressure over the path of the ureter. The latter may even be felt from the vagina thickened and painful. The condition generally begins to improve immediately after the conclusion of labour. Endocarditis is a dangerous complication. The disease fairly frequently causes premature expulsion of the uterine contents. Treatment consists in rest in bed, by which means the pressure of the uterus on the ureters becomes less, and at the same time urinary antiseptics, copious drinks, and dietetic treatment are of the utmost importance. Surgical treatment may perhaps also be required. G.

The Intestinal Disturbances of Breast-fed Infants.—As a result of the examination of twenty breast-fed infants during the period from the second to the fifth days of their life, Schahort (*Monatssch. für Geb. u. Gyn.*, Bd. 24, Hft. 1) observed green stools in every case without exception. He found that during the same act of defæcation yellow-coloured matter may be followed by green, or the motion at first green may finally become yellow; and again, although in some cases the daily stools consecutively showed the normal colour for a time, they also ultimately became green. In short, the stools of these infants of three to five days' old were without exception those which can be described as dyspeptic. The transition of this condition to one of normal stools occurred in some of the cases at very varied intervals. From bacteriological examination, the author found that the contents of the rectum immediately after birth were always sterile. The time of the first infection was quite independent of nutrition. Bacteria were found in the meconium from 10 to 20 or more hours after birth. With the appearance of the milk stools the bacillus acidophilus and the bacterium coli were regularly discovered, and in 2½ to 4 days after birth, in addition to the latter, diplo- and staphylo-cocci were found in every case. The disturbances of digestion increase at the same rate at these cocci make their appearance, and the earlier they appear the more severe are the clinical symptoms. The number of these cocci varies according to the severity of the symptoms, and of them the staphylococci are associated most strikingly with the intestinal disturbances. The sources of this staphylococcal infection are very varied. It may arise from air infection, or from substances coming into contact with the infant—e.g., vaginal secretion, bath water, lochial secretion, etc. Cohn and Neumann have shown that the breast milk regularly contains staphylococci, most frequently albus, which have made their way from outside into the milk ducts. It is therefore clear that the milk, when there are long intervals between the nursing, and also during the first suckling, must be rich in staphylococci, and particularly the first milk extracted. Escherich has shown that the milk of septic women contains staphylococci. The clinical symptoms vary very much in the different cases, and undoubtedly depend on the power of resistance of the infant, as well as on the number and virulence of the infecting staphylococci. The question whether the intestinal catarrhs which play so important a part in infantile mortality during the first year of life are fresh exacerbations of chronic intestinal disease, which, beginning in the first days of life, takes on acute forms with every new and severe irritation, or whether, on the other hand, these catarrhs remove a good deal of the resisting power of the infantile organism, and thus render it incapable of resisting later bacterial invasion during the first year of its life—the author leaves this question unanswered. He considers that either may be possible. He believes that icterus neonatorum and these intestinal affections of the first days of life are ætiologically connected. G.

Primary Carcinoma of the Ovary.—McIlroy (*Jour. Obst. and Gyn.*, October, 1906). In an exhaustive paper the author draws the following clinical conclusions with regard to primary carcinoma of the ovary. It occurs at or near the menopause, although found in patients of 24, 25, and 29 respectively. It is almost as frequent among nulliparous as among multiparous patients, previous pregnancies having little or no influence on the disease. Pain is not a marked symptom, patients seeking advice for the relief of the abdominal swelling with its concomitant symptoms. and ascitis is present in all cases. It has a marked influence on menstruation, tending to cause cessation of the periods, but previous dysmenorrhœa was not a marked symptom in any of the cases. There is often little or nothing to suggest the diagnosis of malignancy, and the patient may be in good health until a few weeks before seeking advice; whereas in secondary carcinoma of the ovary emaciation and feebleness are rather prominent symptoms. In most cases the growths are bilateral, generally mobile, and sometimes, if of large size, are entirely extra-pelvic in situation. Metastatic growths depend on the degree of advancement of the growth and on the integrity of the capsule, and have been found in the bladder, uterine wall, and behind the prevertebral peritoneum. The mortality of operation is high, and recurrence is probable. F.

Mitral Stenosis and Pregnancy.—French and Hicks (*Jour. Obst. and Gyn.*, September, 1906). There are certain points in regard to valvular heart disease and pregnancy upon which there is general agreement. They are—Mitral Stenosis, is the form most commonly accompanied by heart failure during pregnancy; Aortic lesions without mitral are rare in women; and few cases come under observation where symptoms of heart failure have preceded pregnancy. They are made worse by pregnancy, and repeated pregnancies at short intervals cause greater risk of heart failure than do few pregnancies at longer intervals. On the other hand, there are some points upon which there is not the same agreement, and amongst these one of the most important, perhaps, is the question of whether a young woman with mitral stenosis should marry. Having analysed the obstetric histories of 300 women, over twenty, who had mitral stenosis, the authors conclude—That it is not just to absolutely negative marriage in all women with mitral stenosis, and that the dogmatic "no" of Jellett and Porak is unjustifiable. It is right that the physician should make clear to the contracting couple, or to their near relatives, the risk run. If the woman has survived the age of twenty with good cardiac compensation, the likelihood that pregnancy will accelerate the time of heart failure does not seem to be so great as has been declared in text-books, and whether the woman marry or not, it is likely that she will not reach old age. That comparatively few are sterile; that they are not especially liable to abort. That the majority bear children well. That when heart failure develops in relation to pregnancy, it is very often not with the first pregnancy, but after several pregnancies. That the treatment should be the same as for a non-pregnant patient with mitral stenosis. F.

Urethral Bacteria as a Factor in the Etiology of Cystitis in Women.—Taussig (*Amer. Jour. of Obst.*, October, 1906). In discussing the etiology of cystitis in women, we must distinguish three main channels of infection, one by way of the ureters, a second directly through the bladder wall from the surrounding structures, and the third from below by way of the urethra. Of these three by far the most frequent route of infection is the urethral. In general, we may say the ureter acts merely as a channel to carry infectious germs from the kidneys to the bladder. The ureters themselves are normally free from germs, and are rarely the primary source of the infectious material. Likewise the bladder wall is seldom a primary seat of infection, but is only secondarily penetrated by suppurative processes, such as pyosalpinx, etc., or by the invasion of colon bacilli from the rectum. How does this rule apply to the third channel of infection—the urethra? Taussig made bacteriological examination of the urethral secretion of fifty women free from any disease of the urinary track or acute pelvic inflammation. The results of the examination, with the lessons to be drawn therefrom in the way of prophylaxis, may be summarized as follows:—1. The normal urethra free of disease is sterile in only a small proportion of cases—8 out of 45 cases. 2. In about half of the urethræ examined pathogenic germs are present. 3. Of the pathogenic bacteria found staphylococcus pyogenes albus is the most common; the occurrence of the colon bacillus seems very variable—it is found frequently where patients are confined to bed. In his series it was only isolated three times. 4. That these urethral bacteria are actually carried into the bladder by catheterisation. 5. Irrigation of urethra with boric acid removes a large proportion of the urethral bacteria; but where the number is great does not suffice to re-remove all. 6. Wherever repeated catheterisation becomes necessary, certain precautions to prevent infection of the bladder should be advised. Give urotropin, or an allied product, internally, and where catheterisation is necessary for a considerable time it is certainly advisable to use boric acid irrigation after each catheter is passed. F.

Chorea Gravidorum.—French and Hicks (*Practitioner*, August, 1906). In a series of twenty-nine cases these observers found a previous history of chorea or rheumatism in nineteen cases. Chorea may be absent during the first pregnancy, yet occurs in a later one. It may come on at any time, but is distinctly less likely to occur during the later months. When chorea occurs in successive pregnancies it is likely to begin in the same month each time. The pathology is similar to that of infantile chorea, and occurrence is frequent. As regards prognosis, a rise of temperature above 100 Fahr. would justify a grave prognosis, whereas a normal temperature would justify a good one, as far as immediate results were concerned, regardless of the severity of the choreic movements. The majority of cases do well when treated in exactly the same way as non-pregnant cases. The induction of labour is seldom called for, even when movements are severe, and after pyrexia has set in it is too late. The mortality is about 10 per cent. F.

The Rubber Teat and Deformities of the Jaws.—Pedley (*Brit. Med. Jour.*, October 20th, 1906) contributes a long article on the subject of the deformities which may be caused in the jaws of infants by the prolonged use of the ordinary form of rubber teat, and of the so-called "comforter." The paper is illustrated by a large number of drawings of casts of such jaws which the author has met with in his practice in Burmah. The author considers that the defective shape and resiliency of the artificial teat, the severe muscular efforts demanded of the tongue, and its altered shape in sucking it, the extra muscular pressure of the lips and cheeks, the enormously increased atmospheric pressure upon the cheeks and jaws, are all abnormal influences which must have injurious effects upon the delicate bony tissues of the infantile maxillæ, and interfere with their proper growth and development. The ossifying junctions of the maxillæ, the premaxillæ, and the mandible are subjected to these unnatural influences during a long period when they are most liable to be injured. When these processes are prolonged, as they often are, until the temporary teeth have all been erupted, or even into the third or fourth years, it is not surprising that the alveolus containing the upper incisors, both temporary and permanent, should be pushed forward, for the bulk of the premaxillæ is alveolus. At the same time the upper alveolar arch, instead of broadening, is compressed transversely by the atmospheric pressure upon the cheeks. This, with the pressure of the bulk of the teat against the palate, destroys the symmetry of its concavity by preventing the descent which accompanies natural development. The palatal arch may thus remain abnormally high in the centre, and sometimes becomes V-shaped. The author's conclusions are: When an infant is deprived of its mother's milk and has to be fed by hand,, the substitute should be quite different in shape and consistency to the patterns now in vogue. It seems so difficult to make, even in india-rubber, a good imitation of Nature, that it would be much safer to be satisfied with providing a soft end to the spout of a vessel from which the infant is to be fed, and through which the milk can be gently and slowly poured into its mouth. No harm can result from a baby drinking without sucking. As a substitute for the common rubber teat, he recommends the use of a good-sized soft rubber finger-stall. Such a teat may be used on the spout of a vessel like a feeding-cup, or an ordinary feeding-bottle. A baby three months old can quite easily be taught to drink from a cup, and at this age he recommends that all teats and bottles be thrown aside, and that we should revert to the old-fashioned metal pap-bowl with the long open lip.

Pharmaceutical Society of Ireland.

Pharmaceutical Licence Examination.—The following passed:—John Alexander Donaghy, Charles Agnew, Thomas James White, William Edmond Walshe. Five candidates were rejected.

Registered Druggist Examination.—The following passed:—William Manning, Isabella Unsworth. Six candidates were rejected.

NOTICES TO CORRESPONDENTS, &c.

☞ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to 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 proofs.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

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.

SUBSCRIPTIONS.

SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance.

R. R. R. (Liverpool).—On enquiry we are informed that a play, in which "Syphilis" played an important part, was submitted to certain Paris theatrical managers with a view to its production on the stage. This was refused, but it subsequently appeared at one of the theatres in Brussels. We have not heard of a translation being made for the English stage, for the obvious reason that the Lord Chamberlain would refuse licence, even should any stage manager be found willing to produce it.

ADVOCATE.—We quite agree that it is wrong for novelists to use the actual names of well-known physicians in their stories. But we do not think any steps could be taken to restrain the practice, unless the intention to libel were obvious.

R.A.M.C. (Vol.).—There have been two well-known types of service water cart. The first pattern was found unserviceable, but the second seems both practical and efficient.

ANEURYSM.—The Röntgen Rays cannot be considered of any value in aneurysm of the abdominal aorta, unless a positive result is obtained. A clearly defined shadow of course would be valuable confirmatory evidence.

D. S. T.—The upright position for the administration of anæsthetics in throat operations is quite common; it cannot be considered unorthodox.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, OCTOBER 24th.

HUNTERIAN SOCIETY (Metropolitan Hospital, Kingsland Road, N.E.).—4 p.m.: Clinical Afternoon.

POST-GRADUATE COLLEGE (West London Hospital).—10 a.m.: Diseases of the Throat, Nose, and Ear. Diseases of Children. 2 p.m.: Medical and Surgical Clinics. 2.30 p.m.: X-Rays. Operations. 5 p.m.: Lecture:—Dr. Beddard: Practical Medicine.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. J. Berry: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. G. H. Savage: The Insanities of Visceral Diseases.

LONDON SCHOOL OF CLINICAL MEDICINE (Dreadnought Hospital, Greenwich).—2.30 p.m.: Operations. 2.30 p.m.: Dr. R. Wells:—Medicine. 3.15 p.m. Mr. M. Robson:—Surgery. 4 p.m.: Mr. Cargill:—Ophthalmology. Out-patients Demonstrations:—10 a.m.: Surgical and Medical. 11 a.m.: Eye.

CENTRAL LONDON THROAT AND EAR HOSPITAL (Gray's Inn Road, W.C.)—5 p.m.: Demonstration:—Dr. W. Wingrave: Clinical Pathology.

THURSDAY, OCTOBER 25th.

HARVEIAN SOCIETY OF LONDON (St. Mary's Hospital).—8 p.m.: Cases will be shown by Dr. S. Phillips, Dr. A. P. Luff, Dr. W. Harris, Dr. J. Broadbent, Dr. S. Spicer, and Mr. J. Clarke. 8.45 p.m.: Clinical Meeting.

POST-GRADUATE COLLEGE (West London Hospital).—2 p.m.: Medical and Surgical Clinics. 2.30 p.m.: X-Rays. Operations. Diseases of the Eye. 5 p.m.: Lecture:—Mr. Baldwin: Practical Surgery.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC.—4 p.m.: Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m.: Lecture:—Dr. C. O. Hawthorne: The Field of Vision in Health and Disease.

LONDON SCHOOL OF CLINICAL MEDICINE (Dreadnought Hospital, Greenwich).—2.30 p.m.: Operations. 2.30 p.m.: Dr. G. Rankin: Medicine. 3.15 p.m.: Sir W. Bennett: Surgery. 4 p.m.: Mr. M. Davidson: Radiography. Out-patient Demonstrations:—10 a.m.: Surgical and Medical. 12 noon: Ear and Throat.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.)—6 p.m.: Chesterfield Lecture:—Dr. M. Dockrell: The Treatment of Eczema in all its Forms.

FRIDAY, OCTOBER 26th.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8 p.m.: Clinical Evening for the Exhibition of Clinical Cases, followed by Discussion. Patients in attendance at 8 p.m.

POST-GRADUATE COLLEGE (West London Hospital).—2 p.m.: Medical and Surgical Clinics. Diseases of the Throat, Nose, and Ear. 2.30 p.m.: X-Rays. Operations. Diseases of the Skin. 5 p.m. Lecture:—Mr. Pardoe: On the Diagnosis of Surgical Diseases of the Kidneys and Ureters.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC.—4 p.m. Dr. J. Horne: Clinique. (Ear.)

LONDON SCHOOL OF CLINICAL MEDICINE (Dreadnought Hospital, Greenwich).—2.30 p.m.: Operations. 2.30 p.m.:—Dr. R. Radford: Medicine. 3.15 p.m.: Mr. McGavin:—Surgery. Out-patient Demonstrations. 10 a.m.: Surgical and Medical. 12 noon: Skin.

SATURDAY, OCTOBER 27th.

POST-GRADUATE COLLEGE (West London Hospital).—10 a.m. Diseases of the Throat, Nose, and Ear. 2 p.m.: Medical and Surgical Clinics. 2.30 p.m.: X-Rays. Operations.

LONDON SCHOOL OF CLINICAL MEDICINE (Dreadnought Hospital, Greenwich).—2.30 p.m.: Operations. Out-patients Demonstrations. 10 a.m.: Surgical and Medical. 11 a.m.: Eye.

Vacancies.

City of London Hospital for Diseases of the Chest, Victoria Park, E.—Pathologist. Salary £110 per annum. Applications to Henry T. Dudley Ryder, Secretary.

St. Bartholomew's Hospital, Rochester.—House Surgeon. Salary £110 per annum, with board and residence at the hospital. Applications to Frederick F. Smith, Clerk to the Trustees, 42 High Street, Rochester.

St. Bartholomew's Hospital, Rochester.—House Physician. Salary £110 per annum, with board and residence at the Hospital. Applications to Frederick F. Smith, Clerk to the Trustees, 42 High Street, Rochester,

Newcastle-on-Tyne Dispensary.—Visiting Medical Assistant. Salary £160 per annum. Applications to the Honorary Secretary, Joseph Carr, Chartered Accountant, 26 Mosley Street, Newcastle-on-Tyne.

Clayton Hospital and Wakefield General Dispensary.—Senior House Surgeon. Salary £120 per annum, with board, lodging, and washing. Applications to the Hon. Secretary, Clayton Hospital, Wakefield.

Macclesfield Parkside Asylum.—Junior Assistant Medical Officer. Salary £140, with apartments, board (no alcohol), and washing. Applications to the Medical Superintendent.

Aston Union.—Resident Assistant Medical Officer. Salary £140, with furnished apartments, rations, and washing. Applications to John North, Clerk to the Guardians, Union Offices, Vauxhall Road, Birmingham.

Bradford Children's Hospital.—House Surgeon. Salary £100 per annum. Applications to C. V. Woodcock, Secretary, Bradford.

County of Lanark.—Middle Ward Isolation Hospital.—Resident Physician. Salary £140 per annum, with board, &c. Applications to W. E. Whyte, District Clerk, District Offices, Hamilton.

Stockport Union.—Stepping Hill, Hospital.—Resident Assistant Medical Officer. Salary £130 per annum, together with furnished apartments, rations, &c. Applications to C. F. Johnson, Clerk to the Guardians, Union Offices, Shaw Heath, Stockport.

County and City Infirmary, Waterford.—House Surgeon. Salary £100 per annum, with board, &c. Applications to E. O'Farrell, Secretary. (See advt.)

Fermanagh County Hospital.—House Surgeon. Salary £52 per annum. Applications to C. Wilson, Secretary. (See advt.)

Appointments.

HAMMOND, E. A., M.D., C.M., Clinical Assistant at St. John's Hospital for Diseases of the Skin, Leicester Square, London.

KENNEDY, EDWARD, L.R.C.P. and S.Irel., Clinical Assistant at St. John's Hospital for Diseases of the Skin, Leicester Square, London.

MCGLASHAN, J., M.D.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Newhaven District for the county of Sussex.

MCQUEEN, J., M.B., Ch.B.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Cumnock District of the county of Ayr.

NUTTALL, G. H. F., F.R.S., Quick Professorship of Biology at Cambridge University.

ST. JOHNSTON, T. R., M.R.C.S., L.R.C.P., L.S.A., Second Resident Medical Officer to the Lewisham Infirmary.

THOMPSON, A. G., M.B., B.Ch.Oxon., Clinical Assistant to the Chelsea Hospital for Women.

Births.

HART-SMITH.—On Oct. 16th, at 21 Adelaide Road, Brockley, S.E., the wife of Humphry Morshead Hart-Smith, M.B., B.C., of a son.

WILSON.—On Oct. 18th, at Denham House, Goldhawk Road, London, the wife of James Wilson, M.D., of a son.

Marriages.

HEWETSON—BUSE.—On Oct. 17th, at St. George's, Hanover Square Captain Henry Hewetson, R.A.M.C., fourth son of the late Rev John Hewetson, formerly Vicar of Measham, Leicestershire, to Margaret Elizabeth, eldest daughter of the late Henry Buse, Esq., of Bristol.

HOWES—TIBBITS.—On Oct. 18th, at St. Mary's Church, Warwick, the Rev. Richard Howes, only son of the Rev. W. A. Howes, of Cold Higham Rectory, Northamptonshire, to Ida Jane, second daughter of the late Dr. and Mrs. Tibbits, of Warwick.

Deaths.

CHEYNE.—On Oct. 17, at 38 Colby Road, Upper Norwood, William Romley Cheyne, M.R.C.S., second son of the late Robert Romley Cheyne, F.R.C.S., of 27 Nottingham Place, London, aged 58 years.

MACLEAN.—On Oct. 19th, at 10 Widcombe Crescent, Bath, John Lindsay Maclean, M.D. (of "Echoes of Service"), aged 75 years.

SIDDALL.—On Oct. 19th, at Coaybeare, Northam, Devon, Mary Elizabeth, wife of Joseph Bower Siddall, M.D., C.M., D.P.H.Cantab., late Physician H.B.M. Legation, Japan, aged 62 years.

WOOKEY.—On Oct. 20th, at 20 Moor Mead Road, St. Margaret's, Middlesex, James Wookey, M.R.C.S., L.S.A., late of Potter's Bar, Middlesex, aged 73.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIII. WEDNESDAY, OCTOBER 31, 1906. No. 18.

NOTES AND COMMENTS.

Manchester Midwives.

IT has never been denied by the medical profession that the midwife, if she is to become a part of the medical service of the country, should be educated. It has always been strenuously asserted that the wrong way to educate the midwife is to make her an independent practitioner. Perhaps no medical prediction has so surely and so rapidly been fulfilled as that the registering of free and independent midwives would do little for the poor mother, and most of that little bad. We note that in Manchester for the first nine and a half months of this year there have been no less than thirty-four cases of puerperal fever in the practice of midwives and eight deaths. Is that an indictment of the system? No, say the midwife's backers, it is an argument for it; last year for the same period there were forty cases with twelve deaths. One cannot help remembering that the notification depends on the diagnosis of these highly-trained professional workers.

X-Rays and Sterilisation.

IN speaking of sterilisation in connection with X-rays it is not meant to attribute the bactericidal virtue to the many already possessed by the beams that issue from the Crookes' tube. It is the other kind of sterilisation that is intended; the sterilisation of the mammal. Dr. Martin, the Medical Officer for Health for Gorton, is reported to have lectured recently on the necessity of limiting the families of the fit and obviating the occurrence of families to the unfit. The Psalmist, said Dr. Martin, had remarked that the man was happy whose quiver was full, but to-day it was the parent who quivered at the responsibilities of child-rearing. But to the lunatic, the degenerate, and the diseased, though Dr. Martin would allow a quiver, he would keep him by a judicious administration of X-rays from replenishing it. "The gathering," we read, "comprised both sexes."

Vegetarian, Fruitarian, or What?

THERE are so many people alike in the world that when a man is frankly eccentric there is a good deal to be said for encouraging him. What could be more charmingly refreshing than that Mr. Eustace Miles should write to the *Daily Express* to suggest that some enthusiast should offer a prize of £100 for a satisfactory name for the diet advocated by himself? If Mr. Miles wants a good advertising name for his nuts and biscuits, surely it would not be a bad plan if he offered the £100 himself. Why "some enthusiast"? Why not, one wonders, one of the advertising staff of the *Times*? We shall make no charge for commission if our suggestion results in business.

Our Suggestion.

BUT surely it cannot be so hard to think of a name for this Milesian diet when every other hoarding flaunts the fancy nomenclature of some fresh albumino-phosphate or reduced ox. We are not quite sure what distinguishes Mr. Eustace Miles' particular diet from that of the common or garden vegetarian, but presumably he eschews fish, flesh, and fowl, and advocates some mixture of his own. Being a classical scholar he would probably object to the term "carnophobia" as being a hybrid, and Miles' food would be too much like Milo food, but we would venture to suggest that it might be appropriate to speak of his followers as suffering from "Eustachian stenosis of the diet." If he cares to award us, £100 for the suggestion, we shall be happy to hand it over to the King's Hospital Fund.

Motor Buses and Nervous Exhaustion.

A medical correspondent draws the notice of a lay contemporary to the effect that the driving of motor buses has on the nervous system of the driver. According to his statement the continuous tension created by fear of accident, combined with vibration of the vehicle, gives rise to a form of nervous exhaustion, accompanied with intense fatigue. Yet the subjects cannot sleep properly, and what rest they obtain is broken by nervous starts. We should be interested to hear if any of our readers have noticed similar phenomena in the employés of motor-bus companies. In one case brought to our notice a gentleman, after three narrow escapes in a London street within the space of half an hour, became so nervous that he found himself running across the roadway although no vehicle was near.

Is Mrs. Eddy Ill?

IF Mrs. Eddy is really seriously ill, as is currently reported in America, one would sympathise with her as with any other victim of disease. But one of her followers in denying the report says she is a "surprising illustration of longevity." If, however, illness is merely a falling away from the faith, the only surprising thing is that the leader of "Christian Science" should ever suffer or grow old.

LEADING ARTICLE.

THE HARVEIAN ORATION.

THE Harveian Oration for the year 1906 will be memorable as a display of ripe erudition and wise insight into the evolution of the human intellect. It was delivered by Dr. William Osler, who brought to the task a mental equipment peculiarly fitted for its successful treatment. Year after year the annual panegyric upon Harvey and his great discovery has taxed the ingenuity of the keenest minds in the medical profession, and the time has long gone by when it was possible to say anything new upon the man himself. His great work, however, remains a monumental work for all ages. Inasmuch as the discovery of the circulation of the blood laid the foundation of all modern pathology, the Harveian lecturer, by a judicious application of that truism, is enabled to review the whole field of medical progress. One of the keynotes struck by the Lecturer of 1906 is tersely expressed in the remark of Locke, himself a physician, to the effect that "Truth scarce ever yet carried it by vote anywhere at its first appearance." The frame of mind that three hundred years ago for a time overwhelmed Harvey with a flood of neglect, ridicule, and contempt has hitherto been the rule in the history of scientific achievement. In the present generation two striking instances may be cited in the widespread opposition which met Koch's discovery of the bacillus of tubercle and Lister's aseptic surgery. As Dr. Osler pointed out, both these truths were in the latent possession of scores of workers, but it remained in each case for the genius of a single mind to evolve the brilliant demonstration. At the same time he added the comforting reflection that the times are changing with regard to the receptivity of fresh discoveries. In support of that proposition, he contrasts the cordial welcome of the pallid spirochæte with the chilly reception of the tubercle bacillus. "We are better prepared to-day, and a great discovery like that of Shaudinn is immediately put to the test by experts in many lands, and a verdict is given in a few months. We may have become more plastic and receptive, but I doubt it; even our generation—that great generation of the last quarter of the nineteenth century—had a practical demonstration of the slowness of the acceptation of an obvious truth in the long fight for the aseptic treatment of wounds." Receptivity of new ideas, indeed, becomes difficult to most men after attaining middle age, and it is difficult to estimate the amount of mischief done by those in authority who still cling to the erroneous views of their earlier life. The progress of truth is slow, but in the end its triumph, in spite of all difficulties, is inevitable, a statement that applies to all spheres of human activity. This slowness of general acquiescence has probably proved fatal to many a great intellect, with all the finely-tempered and emotional qualities that as a rule accompany genius. In presenting a graphic picture of Harvey's life, the lecturer threw into high relief the blindness to things at their feet that may affect even the most illustrious observers. This tendency is illustrated in the case of Harvey himself by his refusal to recognise the truth of the lymphatic circulation. No less interesting is the failure of so acute a man as Fabricius, an enthusiastic teacher and investigator, to grasp the inwardness of the study on which his pupil, Harvey, was destined later to found an undying reputation. The mystery of this oversight is expressed by Dr. William Osler in the following fine passage. "How Fabricius, a man who did such work—how a teacher of such wide learning and such remarkable powers of observation, could have been so blinded as to overlook the truth which was tumbling out, so to speak, at his feet, is to us incomprehensible. But his eyes were sealed, and to him, as to his great predecessors in the chair (at Padua), clear vision was denied. The dead hand of the great Pergamite lay heavy on all thought, and Descartes had not yet changed the beginning of philosophy from wonder to doubt." There can be little doubt that many such mysteries await the evolution of medicine into the position of even a fairly exact science. Meanwhile it would be well to apply the moral of the Harveian orator, and to ask ourselves from time to time whether we may not be rejecting obvious truths and closing our ears to the gospel of unrecognised prophets in our midst.

NOTES ON CURRENT TOPICS.

Medical Service in the Field.

The recent experiment at Bulford in the shape of a camp of instruction in field hospital work, under the direction of Colonel Dundon, will we hope lead to more extensive work of the same sort. It has become a platitude to remark that in a campaign disease is more to be feared than the enemy. It is, however, matter for rejoicing that the Army authorities seem at length to recognise this. Precautions against disease must, of course, come in the first instance from the medical officers, but it is essential for their success that the strictest hygienic regulations should be drawn up, breach of which should be regarded as a serious offence against discipline. It is necessary also that combatant officers should not only receive but accept advice from medical officers as to the site of a camp; and that, unless it be unavoidable, no camp should be occupied for longer than a fortnight. Colonel Dundon's camp at Bulford, however, was more particularly concerned with instruction in ambulance work, which also stands in need of much improvement. At present, when a man falls he is carried off by three or four of his comrades, thereby weakening the firing line to a considerable extent. Any method, therefore, which renders more rapid the removal of the wounded from the field will help forward the efficiency of the army as well as to the cause of humanity.

Convalescent Homes in London Parks.

The question of devoting the empty mansions situated in the London public parks to a beneficent

purpose of providing convalescent homes has frequently been discussed, and the London County Council has always expressed itself in favour of such a scheme. The rebuff, therefore, administered by the Parks Committee of the Council to an influential deputation who recently waited on them in connection with this matter came rather as a surprise. The deputation representing the Convalescent Homes Association, led by Sir William Church, asked that the house at Golder's Hill might be given over for use as a convalescent home for children. In reply, the members of the deputation were told that the first floor of the mansion, the best part of a very fine house, was let at a rental of £15 a year! It is intolerable that a nominal sum such as this should block an important humanitarian scheme, and it is doubtful whether the County Council were even aware of the letting of the house. In fact, the transaction seems to have been smuggled through the Council in a peculiarly shady manner. The matter is all the more inexplicable as some time ago the Parks Committee recommended to the Council "that any houses and mansions in the Council's parks which are suitable for the purpose should be allowed to be used as convalescent homes." We trust that the letting of the house at this absurd sum will soon come to an end, and that a boon may then be conferred on the sick children of London.

French Minister of Public Health.

Among the things they do better in France is to welcome to their legislature medical men and medical views. It is possible in France—indeed, it is far from uncommon—for medical men to carry on a life of public political utility, whilst with us only a few academic medical representatives or men of means are able to do so. Moreover, medical men here necessarily enter political life late, and therefore seldom have a chance of attaining more than very minor posts of influence in the Ministry. In France, on the contrary, a medical man has actually been premier, and the Ministry generally includes one or two representatives of the profession. One is not, therefore, surprised to find that M. Clemenceau's new Ministry have already created a new office, that of Minister of Public Health and Labour, such as is urgently needed in this country. Not till there is a Minister specially charged with public health functions can we expect the subject to assume the full importance it deserves, and in the present case in France its conjunction with Labour forms a happy illustration of how closely the science of hygiene is bound up with the well-being of the working classes. Indeed, to the credit of the Labour Party in the present House of Commons may be attributed their zeal for the medical inspection of school children and cognate reforms.

Derby Guardians and Vaccination.

As we recently anticipated, the Derby Guardians have received a well-merited snub from the Local Government Board. The Guardians, it may be remembered, were called upon to appoint a new vaccination officer, and they took the opportunity to make it a condition of appointment that no prosecution of defaulters should be undertaken except at their initiative, and it may be guessed how often that initiative would be taken. This power of initiative was wisely reserved by the legislature for the Local Government Board, perhaps the only wise thing about the Vaccination Acts. At any rate, the Guardians at Derby have received a letter from the Board saying that the condition demanded of candidates for employment is illegal, and that they therefore decline to sanction the appointment of the officer selected. There will therefore have to be a new election, with its consequent trouble and expense, and if the same officer is elected again under the new conditions it is highly likely that the Local Government Board may again demur. Those who dislike a law would consult their own dignity and the public interest better, either by not seeking election to Boards charged with its administration, or by divesting themselves of their prejudices when placed in authority.

The Cost of "Fever."

The economic aspects of disease are far from being recognised at their proper value. The cost of preventable maladies falls not only upon the individual, but also upon the community, which in the long run has to bear the loss inflicted by the crippling and death of its citizens. Hence money paid for sanitation—which in its essence is the same as prevention of unnecessary disease—represents a sound investment by way of insurance premium paid by the ratepayers. In the municipal elections now going on throughout the kingdom many arguments have been advanced by persons who fail to grasp the first principles of public health expenditure. In the case of the Metropolis, for instance, it is shown that while the County Council and other local bodies have during the past three years spent something like £70,000,000, much of it in enforcing sanitation, nevertheless the Metropolitan Asylums Board has during that period spent nearly two millions upon fever. The obvious answer is that had the splendid service of the Board not been available for the isolation, disinfection, and treatment of Londoners suffering from infectious disease, the total loss to the community would have been infinitely greater. It is possibly the best investment of the whole £70,000,000.

The Midland Medical Union.

The pernicious effect of contract or club medical practice upon the medical profession has long been recognised. If protest take no stronger form than pious resolutions, however, things are likely to go on indefinitely in the same unsatisfactory manner. The Midland Medical Union have resolved to strike for themselves, and if the local profession can for once be induced to act in unison they should be able to control the situation. At a recent meeting the Union unanimously adopted the following reso-

lution :—"That it is desirable in the interests of the profession that immediate steps be taken for the formation of a public medical service on the following lines :—(1) To provide attendance for those members of the community who are not in a position to pay ordinary medical fees. (2) The service to be under the entire control of the medical profession in the district. (3) The service to be open to every medical practitioner in the district who so desires, provided he holds no 'private medical club.'" If carried into practice this will mean that the clubs will be under the control of medical men instead of lay committees. Obviously, if medical men act together they can boycott the clubs and friendly societies in the supply of qualified practitioners. The only danger is the presence of medical "blacklegs" who will accept appointments independently. Meanwhile, the Midland experiment is of supreme importance to the profession, which would do well to bear in mind more generally the old motto, "God helps those who help themselves."

Violet Leaves and Cancer.

THERE can hardly be a more distressing sight to the humane medical man than the spectacle of patients suffering from cancer falling into the hands of quacks. Among the host of so-called "cures" that have been foisted upon the public from time to time no single one has hitherto withstood the test of scientific examination. Among other fantastic remedies violet leaves have had their day and are still being exploited as a commercial asset by charlatans in various parts of the kingdom. The medical profession have unanimously rejected the idea of there being any virtue in violet leaves in the treatment of cancer. That their view is founded upon knowledge is shown by the fact that the chemistry of violet leaves has been thoroughly investigated by Whippell Gadd and others. Yet only a week ago a reported cure of cancer by violet leaves, "internally and externally," ran the round of the papers. The tale presents the usual fallacies. A Liverpool medical botanist treated a lady for alleged cancer of the breast, but there is no scientific proof that the disease was actually cancerous. Secondly, the growth was said to have sloughed out, leaving a healthy cavity. Thirdly, the patient, although improved, is not well. That an unqualified person should be allowed to inflict such cruelty and defraud the public in this way forms a scathing commentary upon the worthlessness of the Medical Acts so far as the protection of the community from ignorant medical practice is concerned.

Naval Medical Service.

THE Naval Medical Service must come into line with the Army. It took the medical profession some ten years to convince the nabobs of the War Office that if educated gentlemen were required for the Army Medical Service it was necessary to pay them for their education, and to treat them like gentlemen. The Navy, which was a distinctly better service than the Army, has now been left behind by the latter, that is, as far as attracting good candidates for its medical department is concerned, and the Lords at Whitehall must look to it that they bring their regulations into line with those of the junior service if they wish to provide their officers and sailors with the best care in times of war and sickness. The stirring address of Sir Lambert Ormsby which we recently published has begun to produce effect, for in last week's *Naval and Military Record* his criticisms are discussed seriously, and to some extent sympathetically. For instance, that journal agrees that it is not unreasonable that medical officers should claim to sit on courts-martial which try offences alleged against surgeons, and it emphatically associates itself with the claim that medical officers should have disciplinary power over hospital and sick-berth staffs. It considers, too, that more surgeons should be passed through the hospitals, instead of the latter employment being reserved for certain individuals to the exclusion of others—a point strongly insisted on by Sir Lambert Ormsby. On the other hand, the *Naval and Military Record* considers that other grievances mentioned are either imaginary or not capable of being rectified, and it concludes with a regret that Sir Lambert should advocate boycotting the service till justice is done. But can the journal point out any other effective method of accomplishing our determination? If so, the profession would be glad to adopt it, but its past experience in dealing with the Army has taught it that "peaceable persuasion" is an unserviceable weapon.

Public v. Fees

To part with money is to some people as hard as to part with life itself; indeed, it happens not infrequently that they seem to set a higher value on their money. Few practitioners have not had the experience of piloting a man safely through a severe illness, only to find their bill conveniently shelved when the time comes to pay. A glaring case of this ineffable form of meanness was shown up at the Clerkenwell County Court last week, when Dr. Douglas Gardiner, of Muswell Hill, sued John Maccoy, engineer and shipowner, of Gateshead-on-Tyne, for £31 15s. 6d. for medical attendance and medicine for his son. It seems that the latter was staying in lodgings near Muswell Hill and was taken ill with abscess of the liver. The illness was a desperate one, and by the care and skill of Dr. Gardiner and Mr. Cantlie, who was called in to operate, the son's life was saved after many weeks' illness. Dr. Gardiner was indefatigable in his attention, visiting the patient as often as two or three times a day, and spending hours dressing his wounds and attending to him. On the son's departure he sent in an account to the father for the exceedingly modest sum mentioned, and received a reply that he (the father) could take no responsibility in the matter. As the son had no money this was tantamount to saying that Dr. Gardiner could whistle for fees, so he promptly brought a County Court action to decide the matter. The defence was simply that the father was not liable, no suggestion of

improper treatment being made. The jury found that the father was liable, and judgment with costs was entered for the plaintiff. We heartily congratulate Dr. Gardiner on his success, and we trust that the action and its result will become known in Gateshead, so that his fellow-citizens may become aware of this shipowner's incredible meanness.

The Despotism of Doctors.

From the Queen's Square Club, W.C., there issue from time to time extraordinary theories and doctrines, but last week came forth a lecture by a Mrs. Fagan, which for inflated nonsense, one would imagine will hold the field for a considerable time. The subject was "The Despotism of the Medical Profession: A Growing Danger to the Public." Some of the more reptilian "rags" have an offensive way of referring to the "tyranny" of doctors, but we have never quite discovered wherein this tyranny lay. If it is tyranny to give advice, the world must be populated with tyrants, and only the most ignorant or sarcastic of people could imagine that the legal powers of the profession were other than a not very polite farce. However, Mrs. Fagan has enlightened us, or rather informed us, for we cannot say that we are much wiser after all. The "despotism" is not of the individual, but of the profession as a corporate body, which presents a "solid front of unanimity." Doctors "never differed from each other's expressed opinions," said this lady. We cannot help being glad that someone at last has been found bold enough to assert that doctors do not differ; so sick are we of hearing the opposite urged with wearisome reiteration. Mrs. Fagan then shows her hand. These terrible doctors—corporately, that is, not individually—have opposed the higher education of women, thinking it bad for future generations. Considering that medicine is the only one of the recognised professions open to women, this is rather a bad shot, but there is worse to come. "The advancement of women has been of immense benefit, and the woman of to-day is nearly an inch taller than a century ago, stronger, and not half so hysterical!" There is a time for everything, but surely the time to crow about the decline of hysteria in women comes rather badly the day after the Suffragette incident in the House of Commons. We may be old-fashioned, but in women we prefer the Georgian "vapours" to Edwardian hooliganism. But perhaps we are despotic.

Christian Science Again.

A correspondent calls attention to an inquest recently held at Hammersmith upon the body of a lady who was being attended by a "Dr." Riley, of Hanover Square. The gentleman named was a Christian Scientist, who did not believe in medicine, and who received a guinea per week for praying over deceased. In the witness-box Riley described himself as a Christian Science practitioner, whatever that may be. He gave an address at Hanover Square and another at Datchett. The letters M.D., C.S., were, he said, his registration form in Boston. He formerly held the M.D. degree of the University College of Missouri, but had been struck off the roll when he joined the Christian Scientists. We quite agree with our correspondent's suggestion that it would be desirable to ascertain the precise legal position of a man professing to practice medicine under what amounts to the assumption of a degree he does not possess. It is to be hoped that the police authorities will inquire into the matter, so that the public may at least be informed as to the value of the claims of Christian Science "practitioners." In the course of his evidence "Dr." Riley made the incredible statement that in cases of infectious disease he called in regular medical men. By the way, why should a scientist shy at fevers?

PERSONAL.

Dr. S. J. Sharkey, physician to St. Thomas's Hospital, will deliver the Bradshaw Lecture before the Royal College of Physicians of London, on Tuesday next, November 6th, the subject being "Rectal Alimentation."

It is announced that a Congress of Military Medicine will shortly be held in Paris. Its declared object is to bring the medical officers of the regular army and the all the officers of reserve into personal and scientific contact with each other.

On December 13th next a suitable entertainment festival will be held at the Philharmonic, Berlin, on the seventieth birthdays of Dr. Wilhelm Waldeger, Professor of Anatomy, and Dr. Ernst von Bergmann, Professor of Surgery, in the University of Berlin.

Professor Noel Paton, introduced by Professor Stockman, last week delivered his inaugural address in the physiology class-room of Glasgow University.

Dr. J. M. Redmond, F.R.C.P.I., was elected President of the Royal College of Physicians of Ireland on St. Luke's Day; Dr. Conolly Norman, Censor and Vice-President; and Dr. John Murphy, Dr. Henry Jellett, and Dr. R. Travers Smith, Censors.

We understand that Mr. Jonathan Hutchinson, F.R.C.S., F.R.S., has kindly placed his educational museum at Selby at the disposal of the vicar for services during the re-building of Selby Abbey, recently destroyed by fire.

Dr. Charles Dundee, of Ballycarry, was last week sworn in as a Justice of the Peace for County Antrim.

Dr. Aubrey D. P. Hodges, of Knebworth, Herts, has been presented by Prince Luigi with a gold watch for his services to his chief of staff who was stricken with fever while travelling with the Prince in Uganda. Dr. Hodges is making investigations into the cause of sleeping sickness in East Africa and the Uganda Protectorate for the Foreign Office, and so came in contact with the Prince.

The Chair of Midwifery and Gynæcology in the Cairo School of Medicine has been offered to Dr. Roy Dobbin, Assistant Master at the Rotunda Hospital, Dublin. The selection of Dr. Dobbin from a large number of candidates from all parts of the kingdom is a compliment to the Dublin School of Midwifery.

Sir Christopher Nixon, Bart., M.D., has been appointed Vice-Chancellor of the Royal University of Ireland in place of the late Monsignor Molloy.

A CLINICAL LECTURE
ON
URETHRAL IMPEDIMENTS TO THE EVACUATION OF URINE. (a)

By R. F. TOBIN, F.R.C.S.,

Surgeon to St. Vincent's Hospital, Dublin.

GENTLEMEN,—Clinical teaching, I take it, consists not in communicating to men classifications of ascertained facts, but in showing them how to work, and in encouraging them in the making of original observations, and in independent reasoning on such premises. It is a process in which the willing co-operation—perhaps ardour would be a better word—of the student is essential. What do you do when you want to teach a puppy to hunt rats? You take the cub with an old "ratter" to a place where a rat has been seen, and you pat him on the back, saying, "Good dog! good dog!" It is even so with clinical teaching. One can only take pupils to the patient, give them a few words of encouragement, and at times join in the hunt to show them how the thing is usually done.

I shall proceed with the two cases before us. In each there is some impediment to the evacuation of the bladder. A. is a man of 60, a farm labourer. For two or three years he has had frequency of micturition. He tells us that he empties his bladder, or supposes he does, on going to bed, but notwithstanding, in an hour or two he is awakened by a want to micturate. The call is repeated a couple of times before daybreak. The frequency is not so troublesome during the day. Now for the physical examination of him. I make a digital exploration of the rectum while he leans over and supports himself by the back of a chair. For present purposes I look on the front wall of the rectum as the back wall of the bladder and urethra. The prostate is considerably and uniformly enlarged. It gives a feeling of resiliency rather than hardness to the touch. The lobes are not distinct; they seem pressed into one; the finger cannot reach their upper edge.

I now ask him to make water. You see he has difficulty in starting it, and now, although he is straining, it does not come in force, but dribbles from the end of the penis. He tells us that he has emptied his bladder—he is sure of it. To see whether he has or not, I draw on these aseptic gloves, and having cleaned the orifice of his urethra—the urethra itself, remember, has been washed (a most important point), in the only way it can be properly washed, by water from the bladder—I pass this recently boiled soft rubber catheter, and at a distance of eleven inches I draw off an even larger quantity of urine than that which he has passed. It is about six ounces. I put both specimens aside to be fully examined in the laboratory.

We now pass to case B. He is about 35. He tells us that he had gonorrhœa when he was 19, and that it lasted on him a long time. A few years later he noticed the stream growing small and irregular in shape, and now he has difficulty at times in passing water at all. He will do so before you. You see it shoots out with some force in a small stream like water under high pressure from a small leak in a pipe. There is almost certainly a stricture. Passing down this gum-elastic sound, the bulbous point of which is in size No. 3, and larger than its stem, I meet with a constriction, through which I can coax it, and which by passing the bulb backwards and forwards I can define to be a band about the eighth of an inch broad at a point on a level with Cowper's gland. When the patient had gonorrhœa years ago, there was, no doubt, ulceration at this point, and the resulting cicatricial tissue laid the foundation of the trouble.

Now in these two cases we are face to face with the chief urethral impediments to the evacuation of the bladder. They call for attention on account of the inconvenience complained of by the patients, on account of the danger of complete retention, and because all impediments to the escape of urine by the back pressure they exercise on the kidneys tend from the outset to interfere with their function, and finally bring about their complete disintegration. It is from the kidneys' point of view that we will consider these cases to-day. It is the most important, and the one most likely to be overlooked. The other aspects advertise themselves. Here are kidneys picked up by me in various parts of the world of men who suffered from impediments to the escape of urine. Look at them carefully, and let them teach their lesson.

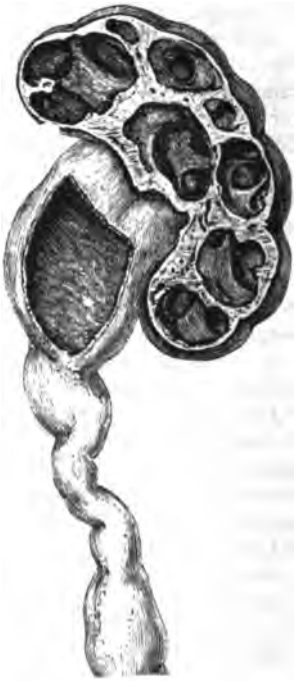

FIG. I.

This is a clinical lecture, and any dissertation on the process by which such changes as those before you are brought about would be out of place. You must study them in works on pathology. May I recommend you one work in particular?—Cohnheim's "Lectures on General Pathology." There is an excellent translation of them by the late Dr. McKee in the Sydenham Series. He is the most interesting of teachers. He takes you along with him. You are pleased as you go; and if you pause and ask yourself why, you will find it is because you have been thinking the whole time, and in the most excellent fashion. Progressive thinking, like progressive jumping, is exhilarating. Supposing such reading done, what will you hear the kidneys saying as to treatment? Only these few words—"Remove the impediments at once."

In a case of stricture it is, as a rule, quite easy. I'll do it for this patient painlessly in a few minutes,

(a) A Clinical Lecture delivered to Senior Students at the Hospital.

with the help of a little cocaine, a Maisoneuve's urethratome, and a No. 12 silver catheter. (Operation performed, and stress laid on the way the knife should be withdrawn if it has been allowed to enter the bladder. In such case only by pressing it back against the posterior wall of the prostatic urethra can it be prevented hitching at the neck of the bladder and making an unnecessary wound.) If this patient will now pass every Saturday night the 9 to 12 Lister's sound, which I'll teach him to use ere he is discharged, the impediment to the evacuation of urine is, in his case, gone, never to return.

In the other case the obstruction is, as we have ascertained, of a different kind. In it the enlarged prostate, by a valvular action, interferes with the discharge of urine. Here is a prostate which you saw me remove in this theatre a month ago. (Fig. II. and Fig. III.). An outgrowth from the middle lobe, or more properly from the middle portion, falls over the outlet of the bladder, and in this instance fits it accurately like the cover of a snuffbox. Pressure, you see, from within the bladder only forces down the lid; pressure on the urethral aspect raises it.

Fig. II

Fig. III.

If you will now examine carefully these specimens of hypertrophied prostate which I hand round (many of them are in sections to facilitate examination), you will notice that the growth has so affected all the structure, including the urethra, that in any removal all must come away together. Further, if you will look at this, the last specimen I'll submit to you (Fig. IV.),

Fig. IV.)

you will see that the change has arranged the tissues in onion-like layers, making enucleation as a rule easy, and, as it were, asking for such interference. Again, in this case, we ask the kidneys, "What is to be done?" Of course, they again say "Remove the impediment." But the job is not an easy one, and not unaccompanied with danger to life, so we must pause. I have no doubt as to its being the treatment that furnishes the largest number of comfortable days and comfortable nights. That is, if A. were to take all cases he met with suffering from urinary troubles owing to senile hypertrophy of the prostate, no matter at what stage, and enucleate the obstacle, and the cases amounted in number to one hundred; and B. were to treat the first hundred cases that came his way by other methods, the years of life falling to A.'s patients in the aggregate would exceed the number falling to B.'s, and if before the word "life" you introduce some such adjective as "comfortable" or "efficient," then the comparison would be still more in favour of A. But, while this is so, there stands out the fact that no major operation is devoid of risk when the kidneys are not sound, and many a patient will say, "What are your averages to me if I chance to be amongst the victims of your heroic procedure?" You must, therefore, use no cocksure rule in dealing with such cases, but, after fully explaining matters, leave a great deal to the discretion of the patient, who knows better than anyone else the extent of his trouble and the conditions that for him make life worth living. Prostatic cases, as they present themselves, may, I think, be considered in three classes:—(1) Those in which there is slight enlargement, with urinary trouble amounting to about two calls at night and two ounces of residual urine. Such cases are, I think, as a rule, best left alone, and kept under observation, the patient being instructed as to what are irritants to the prostate—alcohol, riding, chills, long sittings, etc. Enucleation at such a stage presents more difficulties than it does later on, and as there is always some danger of sepsis from catheterism, it is a question whether the amount of residual urine warrants such risk. If the patient were very urgent to have something done, I would consider the advisability of vasectomy, provided it were a case where the effects of that operation on procreation could be left out of count. That it is prophylactic there can be no doubt; it is, moreover, perfectly safe, detains a patient only a few days in hospital, and no patient on whom I have performed it ever noticed any change in his general condition of mind or body. (2) Patients seriously incommoded by urinary troubles, and with fairly large prostates, and residual urine in excess of the quantity mentioned above. For such cases enucleation is certainly indicated, and should be recommended. It is a well-established operation, with a mortality, in experienced hands, of not more than 10 per cent., and one which changes an ever-increasing

condition of suffering into one of healthful life for those on whom it is successfully performed.

The patient before us is willing to be operated on; he is in every way a suitable case; so to-morrow I will be able to give you a practical demonstration of the steps of the operation.

Those who will not consent to operation must be content to enter on catheter life, with its dangers of sepsis, cystitis, unmanageable retention, and deteriorating kidneys.

(3) To this class belong patients who, after years of discomfort, or maybe of much suffering, with kidneys such as those I have shown you, with sacculated, half-emptied bladders and a condition of the prostate making catheterism difficult, seek surgical advice. What is to be done for these?

Often, in consultations on such cases, when I propose operation, I am met with the remark, "But the kidneys are very much affected." To this I answer, "Yes; but the operation is for the relief of the kidneys. It will drain them as effectually as if the incision engaged themselves." Whoever has made many post-mortem examinations on men with surgical kidneys must have been struck with the small quantity of kidney substance with which a man can carry on and do good work. You may remember the case of a sailor who died here lately, who had been working up to the date of his admission, and of whose kidneys there was little but capsule left. You should bear these points in mind, and, so influenced, you will, I believe, in most cases proceed to prostatectomy or at least drainage of the bladder through a suprapubic opening. About the carrying out of this latter procedure there should not be the least hesitation when in a chronic case great difficulty is met with in passing a catheter. With a hyper-distended bladder it is the easiest of operations. In the median line above the pubis, duly shaved and cleansed, you inject a little cocaine, carry a two-inch incision through the skin, and then, with a blunt dissector, between the recti muscles work down till the bladder is reached. If in doubt as to direction, pass one hand with a glove on into the rectum and work towards it. The bladder being reached, you, standing on the left of your patient, pass a fully-curved needle through a point a quarter of an inch from the centre of the right lip of the incision you have made down through all the tissues into the bladder and then up through a similar line on the opposite side. With a hyper-distended bladder this is a proceeding of no difficulty. You now open the bladder, still using the blunt director, which, without injury to distended veins, goes easily through its muscular walls. With your finger you hitch up out of the bladder the suture just passed, and having divided it, tie each thread on each side. This establishes a clear way into the bladder, no matter how it may contract, and does away with one of the chief dangers of suprapubic cystotomy, the making of false passages in passing drainage tubes and in making examinations subsequent to operation. This procedure, including the washing out of the bladder with boric acid solution through a drainage tube of a size to fill the opening made, need not occupy more than ten minutes.

Your patient is now safe. His kidneys are relieved from all pressure, the urine can flow freely, and there is time to pause to see how he gets on, and to decide whether it is well to do anything further or not. If, when the kidneys have settled down under the new conditions, you find by an examination of the urine that there is some kidney substance still in existence, you will no doubt complete what you have done by an enucleation of the prostate. If, on the other hand, he is beyond such operation, what you have done for him will, when he is provided with a suitable tap and urinal, give to his remaining days as much comfort as they are capable of.

I have put this small operation in detail before you because at first sight it seems more formidable than it is, and it enables a man in a remote place who has no assistant and but few appliances to deal with complete retention of urine from prostatic disease—a not uncommon emergency—in the best possible way, and in doing so make an excellent half-way house on the way to a complete measure.

A Clinical Lecture by a well-known teacher appears in each Number of this journal. The lecture for next week's issue will be by the late Professor Potain, of the University of Paris, on "Latent Diseases." This lecture was almost the last academic utterance of the late distinguished physician, and has not previously appeared in print, having been specially reported for this journal.

ORIGINAL PAPERS.

ON COMPRESSION PARAPLEGIA, WITH A CASE OF REMOVAL OF TUMOUR FROM THE CAUDA EQUINA.

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THIS subject includes a group of diseases which have much in common, and whose therapeutics are based on similar principles. (*a*) In every case of paraplegia the first duty is to ascertain if pressure be a cause, and if so, to locate its site and determine its nature. A correct and precise diagnosis is essential, and stimulated by this necessity a remarkable knowledge of at least the grosser functions of the spinal cord and its individual segments has been gained.

Successful treatment is based on primary facts in physiology and pathology. There is no evidence that repair of cells or fibres ever takes place within the central nervous system. Growth there is, but not birth.

The last impressions which fall upon the sentient cortex of the brain are reflected from cell to cell, harmonised by association of fibres, and traverse the paths of a system whose elements were present at birth. Hence it follows that damage once done whether by the experimenter's knife, by syphilis, or in any other way, is irremediable.

To balance against this is the multiformity of representation of physical actions in the nervous matter. Section of one posterior root produces no enduring anæsthesia, yet that involves the extinction of function of 10,000 cells or more, which compose a spinal ganglion.

Considerable masses of substance may be removed from parts of the brain without any appreciable result, aud degeneration of some fibres in the pyramidal tract occurs without perceptibly modifying movement. Lastly, nervous tissue itself is resistant to disease in a degree exceeding that of other tissues. Of the large number of so-called nervous diseases, the majority are secondary to disease of the nutrient or supporting tissues, and disease may often compress nerve elements and render them incapable of function, without destroying their life, so that if the pressure is removed function may return.

Tumours in the region of the cord may have four sites, arising in the bones, the cord itself, or from the meninges, where they may be either extra- or intra-dural. As the first two are practically inoperable, my remarks will refer only to meningeal tumours. It is difficult to estimate the frequency in which the cord is damaged by tumour. Schlesinger, in 35,000 autopsies, found the cord pressed upon in 100 cases; but this record includes all tumours, whatever their origin, and tumours of bone exceed in frequency all the other forms together. R. T. Williamson has collected references to 110 cases of meningeal tumour, 58 of which were extradural, 52 intradural. Allan Starr considers that spinal tumours are thirteen times less frequent than brain tumours; in his own experience he has treated a hundred brain tumours and

(*a*) "Liverpool Medico-Chirurgical Journal," January 1906.

ten spinal tumours. From these figures it is obvious that the condition is one of considerable clinical importance, especially when it is remembered that in at least half the cases surgical treatment results in complete or marked recovery. The tumours springing from the meninges are commonly hydatid, and varieties of fibromata and sarcomata. When the latter are formed by soft, rapidly growing cells, they tend to invade the membranes and to grow round the cord, from which, however, the growth may be stripped; they infiltrate but do not often destroy the nerve-elements. Though not nearly so favourable for operative treatment as the circumscribed fibromata or hydatid, considerable success may be obtained. It is noteworthy that true gummata of the cord or of the membranes are extremely rare; so also is an isolated tuberculous growth. Neither of these conditions was found in 53 operations.

Symptoms.—The symptoms of extra and intradural tumours are practically the same, and are to be studied, as they give rise to symptoms of irritation of the roots, or interference with the function of the cord. Symptoms from irritation of roots nearly always appear first; hence pain is generally the most important symptom. Its character requires close attention. When due to irritation of the posterior roots it is referred to the peripheral distribution and may be felt at considerable distance from the site of the growth; thus, in a case of tumour at the level of the second to fourth dorsal vertebræ the pain was felt about the region of the left nipple; abdominal pain, at first thought to be flatulent dyspepsia, was the prominent symptom of a tumour at the level of the tenth thoracic segment. When in the cervical region, pain may be referred to the upper limb; in the lumbar or sacral region it radiates along the course of the nerves of the lumbar or sacral plexuses.

The pain is intense in character and often paroxysmal, and the region of the nerve root-supply may be hyperæsthetic; but it is important to note, as distinguishing this pain from that in neuralgia or neuritis, that neither are the painful points of Valleix present nor is there any tenderness along the course of the nerve. From the fact that the tumours are usually small and invade only a slight vertical extent, the pain is often limited in a very remarkable way to the distribution of one or two roots. It may last for a very long time without further symptoms, as in the famous case of Capt. G., recorded by Gowers and Horsley, where pain was almost the only symptom present for three years. Starr remarks that pain of long duration localised to one position should arouse suspicion of spinal tumour. The longer the duration before symptoms of interference with the cord itself appear, the more probable is it that the tumour is extradural and innocent in histological structure.

Sometimes the pain is not due to invasion of a root, but to irritation of the conducting tracts in the cord, and here its site cannot have the same diagnostic or localising value. Painful cramp of muscle resulting from irritation of the anterior roots is uncommon, and such spasm may be reflex. At a later period destruction of the root may take place, and if no other root were affected probably the pain would cease; but anæsthesia or paralysis and wasting of muscles rarely results from this cause.

Symptoms resulting from Interference with the Spinal Cord.

Motor paralysis always precedes sensory loss, and in the first instance produces spastic paralysis in the lower limbs. Should the tumour destroy the ventral cornual cells, paralysis with wasting would be present at that level, but this can only be noticed when the cervical or lumbar regions are the site of the growth. It is of great importance to note that the paralysis often affects one side considerably before the other; but when once paralysis is well marked it usually extends rather rapidly, so that paralysis of one lower limb is soon followed by a paraplegia. The spasticity may be intense and accompanied by violent spasms of the limbs. Sensory loss appears later, and may in some cases, when there is one-sided paralysis, be on the opposite side, giving the well-known Brown-Séquard's syndrome. Its extent on the body marks the level of distribution of the nerve root of the highest segment involved, but owing to the oblique course of the roots the anæsthesia does not correspond with the site of the tumour, which must be determined by a knowledge of the anatomical relationship between the vertebræ and the points of origin of the roots. The knowledge of the sensory supply to regions of the body is the chief guide to precise localisation, and is due chiefly to the work of Ross and Thorburn of Manchester, Sherrington, of Liverpool, Head, of London, Kocker, of Berne, and Allan Starr, of New York. I have found the diagram devised by Seiffer from studies of the work of these and other writers simple and very useful; it shows certain named lines which represent limits of root distribution fairly well agreed upon.

The time taken by this stage of cord symptoms varies much. Continued pressure may set up inflammation, causing a softening of the cord, and the terminal stages rapidly appear; sooner or later conduction ceases between the brain and cord, and often suddenly the picture changes, the spastic state gives way to flaccidity, loss of sensation becomes absolute, the reflexes, with the exception perhaps of the extensor plantar reflex, disappear, and the sphincters are paralysed. Few experiences in medicine arouse so tragic an interest—an interest intensified in many with even little physiological imagination. The patient has become the spinal man; he is indeed two bodies—one still in connection with the centres of life and sense, the other almost lifeless, save for the feeble autonomous action of the spinal cord. Not merely is the lower part of the body powerless and anæsthetic, but the functions of respiration, of the circulation, of the intestines and the urino-genital system are disordered, no longer presided over by the medulla, the most ancient hierarchy in the nervous system.

These are the striking symptoms, as first pointed out by Bastian, of a complete transverse section of the cord. Important discussions, in which most of the distinguished neurologists of the world took part, followed on Bastian's paper. After a rather extensive review of the literature of the subject, published in the *Medical Chronicle*, 1902, I concluded that if the triad of symptoms given by Bastian are present the lesion is certainly complete, but that a slow progressive damage of the cord, going on to the production of complete loss of continuity, does not result in the same symptoms as a rapid destruction of the cord. In these cases rigidity, with increase of the tendon reflexes, may be present. But I have only lately realised how often this barrier, impenetrable to nervous impulses, may be physiological only, caused by pressure, œdema, or evascularisation of the cord. Such a condition is recoverable either spontaneously or by treatment. The symptoms, as far as the nervous system is concerned, must of course be identical, and a recognition of the nature of the lesion can only be made from attending circumstances. Hence we reach the important conclusion, not yet generally realised, that, provided too long a time has not elapsed since their appearance, the triad of symptoms described by Bastian does not necessarily contra-indicate operation, but it may in fact afford the most urgent indication for interference, as in a case of caries under the care of Mr. Monsarrat, in which the spastic condition gave place within 24 hours to flaccid paralysis and absence of reflexes. The result of the operation showed that the surgeon had to deal probably with a condition in which secondary acute myelitis had destroyed all conduction, and no improvement resulted; yet the operation was justifiable, for the condition might have resulted from removable pressure. A number of other cases might be cited.

Lastly, in cases of tumour, we have to consider the symptoms referable to the spine. As a rule these are not well marked, offering a sharp contrast to caries.

There is rarely pain on vertical or lateral pressure of the vertebræ, though some tenderness to percussion may be present over the site of the tumour, and the spine may be sensitive to heat and electricity. These symptoms and the slight rigidity which is often present are probably due to the irritation of the nerves supplying the dura mater.

If the symptoms of gradual invasion of the cord, in the order stated, are present, a tumour is highly probable. In differential diagnosis certain conditions must be excluded :—

1. Tumours of the spine itself, indicated by signs of disease in the bone and the great severity of pain on movement.

2. Caries—here kyphosis and rigidity are especially important; the root pain is not so severe, and constitutional symptoms or evidence of disease elsewhere are present.

3. Syphilis. Gumma is so extremely rare that it should not be diagnosed and precious time lost unless there is a definite history of infection. Chronic meningitis is not uncommon and might give rise to doubt, but here the distribution of symptoms is more random, their vertical extent greater, the cord is rarely much affected, and cerebral symptoms may be present.

4. The hypertrophic form of pachymeningitis described by Charcot has been diagnosed as tumour of the cord. The essential points of distinction are that this condition produces bilateral symptoms from the first, and their vertical extent is greater.

5. I should mention chronic myelitis. A chronic primary inflammatory lesion of the cord should not be diagnosed unless all other diseases are excluded. I submit that the greatest caution is necessary in making this diagnosis; even if the possibility of such a pathological process is admitted, it is most rare. Pain, if present, would be less severe than in tumour. The pain of tumour should not be mistaken for neuralgia or simple neuritis if a reasonable time has been given for observation, and the constant presentation of the same picture has not blunted the alertness of the physician. I may here quote the words of Allan Starr: "In no other disease of the spinal cord do the symptoms of transverse myelitis of gradual onset coincide with the symptoms of persistent pain."

A CASE OF TUMOUR OF THE CAUDA EQUINA.

(*a*) The patient, G., a laundryman, æt. 36, was admitted on August 4th on account of pain in both thighs and weakness of the lower limbs. He had suffered from the pain for about five months; loss of power had developed later. Four years ago he contracted gonorrhœa, followed by stricture of the urethra. On one occasion retention of urine had to be relieved by supra-pubic puncture. Beyond this no history of illness could be elicited. Syphilis was denied, and there was no evidence of it. The father had died from a tumour of the brain at the age of 56. The mother, three brothers, and five sisters are living and in good health. The patient looked ill and worn, and evidently suffered greatly; he was anæmic and somewhat emaciated; weight, 9st. 4lbs. Heart and lungs normal. Nothing could be detected on palpation of the abdomen or by digital examination of the rectum. Urine, sp. gr. 1,016. No albumen or sugar.

Pain.—Severe, spontaneous, shooting pain, often worse at night; it started about the middle line at the level of the highest part of the sacrum, passed downwards over both buttocks and the posterior surface of the thighs, and outside of the legs as far as the ankle, but did not invade the feet.

The pain was much worse when he lay on either side or on the face. It was then referred especially to the lower part of the sacrum. There was sharp pain on flexing the thigh on the pelvis (sign of Lasègue). No particular pain on pressing the muscles of the thigh or legs, or along the course of the great sciatic nerve, or at the points of Valleix.

(*a*) I am made indebted to Dr. John Owen, Medical Tutor at the Hospital, for many careful examinations of the patient.

Spinal Column.—The 1st, 2nd, and 3rd lumbar spines were somewhat uniformly prominent; no pain was caused by percussing these, or by vertical pressure, or by lateral pressure through the iliac crests. There was, however, considerable rigidity of the lower part of the spine. In bending backwards, forwards, or laterally, whilst the upper part of the spine moved, the lower portion remained immobile, and the resulting movement was one of the trunk together with the pelvis on the thighs.

Motor.—There was considerable loss of power in both lower limbs, more markedly so on the left side; inability to raise the left thigh against slight resistance; weakness in the flexors of the leg on the thigh and in muscles moving the feet, though none of these movements were absolutely paralysed. Thus there seemed to be weakness in all the muscles supplied by the lumbo-sacral plexus. All the muscles re-acted to the faradic current, and to a less extent on the left side. Plantar reflex present but ambiguous.

Bladder and Rectum.—Micturition was normal, but the patient stated that he had not as good a control over the action of the bowel as formerly; he had to go to stool quickly in order to avoid soiling himself. On examining the rectum digitally the sphincter ani contracted fairly forcibly on to the finger, and the rectum appeared dilated and ballooned. The patient also stated that he did not feel the examination.

Sensation.—There was marked loss of sensation to touch and pain in the areas figured on the chart. Light touches with the blunt head of a pin were not recognised at all, and a pin-prick was recognised as a dull, just perceptible sensation. This anæsthesia invaded also the penis and scrotum and peritoneum. Testicular sensation was preserved, but there had been neither erections nor seminal emissions for six months.

PROGRESS OF THE CASE.

In the course of a fortnight the symptoms were considerably more defined, and permitted an accurate analysis of the nervous structures involved to be made.

Motor.—The weakness was bilateral, rather more on the left side than right side. Great increase in the weakness of the movement of the feet, which soon became absolutely powerless. On the other hand, the extensors of the legs—the quadriceps group—and the extensors and external rotators of the thighs, though somewhat weaker than natural, acted with moderate force, so that the leg could be raised from the bed. Adduction of the thighs was well performed. The biceps femoris was felt to contract, but feebly. The semitendinosus and semimembranosus also contracted, and apparently not with greatly diminished force. The muscles of the legs were somewhat, but not greatly, wasted. There was no reaction of degeneration, though the faradic irritability was diminished in all the leg muscles. The ankle-jerks remained absent; the plantar reflex could not now be obtained. The left jerk had gradually diminished, and on the 29th August was absent. The right knee-jerk was brisk, and on tapping the quadriceps tendon a lively contraction of the adductors on both sides occured. Abdominal and cremasteric reflexes brisk.

Bladder and Rectum.—On the 23rd August the patient first complained of some difficulty in passing urine—he had to strain. Retention set in a few days later, necessitating the use of a catheter, which the patient was unable to feel. Enemata were required; there was also involuntary passage of fæces and total loss of sensation of the act. The anus was patulous.

Sensation.—The inner sides of the legs were now becoming anæsthetic, the area of loss of sensation in this zone being fairly well defined, and more marked for pain than for touch. The pain remained very severe, necessitating continual administration of morphine. The distribution of the roots forming respectively the lumbar and sacral plexuses is now fairly well agreed upon—the lumbar roots form the

anterior crural and obturator nerves and supply the quadriceps extensor group and the adductors of the thigh; their sensory distribution is on the front and sides of the thigh and inner side of the leg. It is obvious that in the case of G. the functions of these nerves were unimpaired, and that the lesion was one interfering with the function of the sacral plexus. Such an extensive bilateral affection, nearly symmetrical, could be explained only by a lesion interfering with the functions of these nerves either where they are situated close together, forming the cauda equina, or by implication of their centres of origin in the lowest part of the cord itself—viz., the conus medullaris. The limit of the conus has been arbitrarily fixed to include that part of the cord extending from between the origin of the second and third sacral nerves to its termination, a definition which is convenient, since it implies either a total or partial integrity of the lumbar nerves, and further, since it is a clinical fact that lesions of the cauda equina produce symptoms indicating invasion of the sacral roots. Anatomically, indeed, the cauda equina includes the great leash of nerve roots which form both lumbar and sacral plexuses; but, for the reasons just mentioned, its use clinically is restricted to the roots forming the sacral plexus.

In the case of G. the anæsthesia involved all the areas of the sacral aud the last lumbar roots, whilst the muscles belonging to the upper roots were not much affected. At a later period the appearance first of anæsthesia of the inner side of the leg and then of the loss of knee-jerk showed that the fourth and third lumbar roots were becoming involved.

The diagnostic problems were:—(1) Is the lesion in the cord, the conus medullaris, or in the cauda equina? (2) What is its nature? The diagnosis as to the site of the lesion was of great importance, for disease of the conus offers little chance to the surgeon. Here important centres are comprised in a small mass of nervous matter, and the morbid process soon produces its maximum destruction. The cauda equina, on the other hand, is readily exposed, and the nerve roots forming it may suffer only slight and recoverable damage.

The symptoms must necessarily be very similar, since the muscular paralysis, sensory disturbance, and affections of the bladder or rectum may be equally produced by a nuclear (spinal cord) or radicular lesion. The symptoms produced by lesions in either of these situations, referable to the bladder, rectum, and external organs of generation, are of high interest. It can only now be pointed out that the acts of ejaculation of semen and forcible expulsion of the last few drops of urine depend on contraction of the bulbo and ischio cavernosi muscles, which are always paralysed if the lowest part of the cord or the corresponding roots are damaged. It is therefore only by a consideration of the collateral circumstances that a diagnosis can be made. Excluding for the present traumatic lesion, the writings of Raymond and Sappy indicate the following points as being in favour of a lesion of the *roots*:—

1. An insidious onset, with gradual development and progression of symptoms. The conus medullaris gives origin, from a very small extent, to many nerves, and hence disease there is characterised by a rapid course.

2. Pain, violent in nature, spontaneous or excited by change of position or of movement, is in favour of a radicular lesion; moderate pain may be present in either condition.

3. Pain over the vertebral column below the level of the second lumbar spine, exaggerated by percussion and radiating towards the lower limbs, is in favour of a cauda equina lesion. To this I am inclined to add rigidity of the lower part of spine due to irritation of the nerves of the dura mater. Pain higher up, increased by pressure, not radiating very clearly over the lower limbs, is in favour of a medullary lesion.

The sign of Lasègue (pain on flexing the thigh with the leg extended, on to the pelvis), though it may be absent, is a further indication of a radicular lesion.

4. A symmetrical development is a radicular symptom, and perhaps especially suggestive of extradural lesion. Remission of symptoms, especially amelioration in the condition of the bladder and rectum, the slow appearance of muscular wasting, of the reaction of degeneration, and of trophic disturbance are in favour of the cauda equina.

The lesion was therefore considered to be in the cauda equina. As to its nature, it was known not to be a case of injury, and syphilitic and tuberculous processes were thought to be unlikely. The rapid and progressive march of symptoms indicated a neoplasm as the most likely cause, and the diagnosis having been made, an operation was performed by my colleage, Mr. R. W. Murray, on September 2nd, 1904. The spines and laminæ of the 2nd, 3rd, and 4th lumbar vertebræ were removed. On opening the dura mater, a red, soft-looking mass about an inch long was seen surrounded by the nerve roots. It bled very readily, but a considerable portion was removed. Subsequent examination showed the tumour to be an endothelioma or hæmorrhagic angiosarcoma. Rather unexpectedly, the patient improved considerably and regained the power of walking with the aid of sticks, the knee-jerks returned, and the anæsthesia greatly diminished. The pain also was very much relieved. Unfortunately, at about the end of three months symptoms began to return, and pain became again very severe. There could be little doubt from the histological examination that the tumour was maligant and that it had rapidly grown. A second operation was thought to offer some slight chance of relief, but on exposing the nerves it was found that the tumour had grown enormously, and was now from two to three inches long. As the condition was obviously incurable, Mr. Murray and I considered it justifiable to divide a number of the posterior roots. The patient is now completely paralysed in the lower limbs, but though pain was at first relieved it subsequently returned.

I am acquainted with the records of six other cases in which tumours of the cauda equina have been removed, four with almost complete success, one of these being recently under the care of Dr. Ferrier and Sir Victor Horsley. The two remaining, like ours, were malignant sarcomata, and in one of these the operator decided, as we did, to cut the posterior roots in order to spare the patient an agonising end.

Altogether some 26 cases of tumour of this region are known to me, many of which could undoubtedly have been successfully treated. The diagnosis of the exact site of injury in this region is also, and for the same reasons, of the utmost importance, and I quote van Gehachten's conclusions for the guidance of the surgeon:—

1. If no lesion of the vertebral column is found, it is probable that the medulla spinalis will have been injured.

2. In lesions of the first lumbar vertebra or above, the conus medullaris is alone affected.

3. Injury to the second lumbar vertebra causes damage to either the cone or cauda equina, because the level at which the cord terminates varies; in lesions of this vertebra, therefore, injury to the cone cannot be excluded.

4. Injury below this level causes damage to the cauda equina only.

We owe much to Raymond of the Salpêtrière for his work on these finer points in diagnostics and for his records of other pathological conditions affecting this region.

In conclusion, I plead for a close co-operation of the surgeon and physician in dealing with disorders of the nervous system. In no branch of medicine is it more desirable. Such a co-operation is one of the reasons why the Queen's Square Hospital has

so wide a fame, and can only result in benefit to the patient and the advancement of medicine. The science of the surgeon and the high polish of his skill make the history of his art a wonderful story. The hands of the physician are tied by tradition; but those traditions carry too the burden of *Noblesse oblige*, for he cannot be unmindful of the great labourers of the past, many of whom were physicians, who have placed the physiology of the nervous system on a secure and enduring foundation. It is fitting, therefore, that the physician and surgeon should work together in the study and treatment of these diseases.

FURTHER WORK ON THE CHEMISTRY OF VIOLA ODORATA. (*a*)

By H. WHIPPELL GADD, F.C.S.

IN a communication which I read before this Society in December of last year, some experiments were described which, although they had failed to isolate a glucoside, provided strong evidence of the presence of one, and it was presumed that this was the Viola-quercitrin described by Professor Mandelin as having the formula $C_{43}H_{42}O_{24}$.

It has since, however, been pointed out to me by Mr. A. G. Perkin, of the University of Leeds, that Mandelin's formula is incorrect, and that the correct formula for Viola-quercitrin is $C_{27}H_{28}O_{16}$.

Mr. Perkin found this Glucoside in the flowers of the Viola odorata, but in smaller amount than in those of the Viola tricolor.

At my request he has very kindly made some dyeing experiments with an extract which I prepared from the leaves of the Viola odorata, and which was calculated from its yield of glucose to contain about 5 per cent. of Viola-quercitrin ($C_{27}H_{28}O_{16}$.)

Pieces of cloth were mordanted respectively with aluminium, chromium, tin, and iron, and were then divided into two portions. One portion of each was treated with 2 c.c. of a liquid extract of violet leaves, this quantity being equal theoretically to 0.1 per cent. of Viola-quercitrin.

The other portions were treated with a solution containing 0.05 gramme of Viola-quercitrin obtained from eucalyptus.

On comparing the results, it was found that the pieces treated with the violet extract could hardly be seen to be dyed at all, whereas those treated with the solution of Viola-quercitrin from eucalyptus were coloured deeply.

It was therefore evident that there was a mere trace, if any, of Viola-quercitrin present.

All attempts to isolate and identify a glucoside from the violet leaves have failed, and no other principle has been detected.

Attempts to isolate a ferment have also been unsuccessful. The only positive fact resulting from the experiments is that the leaves and their preparations yield, under certain conditions, glucose.

Determinations have therefore been made of the amount of glucose yielded, as this is apparently an indirect measure of strength.

Thus I have found that the amount of glucose from the dried leaves is only about half that from the fresh; that the stalks of the leaves yield about five-sixths the amount obtained from the leaves freed from stalks; that the roots yield practically no glucose; that the juice prepared by expression of the leaves yields as much glucose as the leaves themselves; that a fresh infusion contains nine-tenths of the glucose that can be obtained from the leaves; and that the leaves can be exhausted by continuous percolation with dilute ethylic alcohol solutions, but that it takes a very large volume of the menstruum to exhaust a comparatively small quantity of leaves.

The following experiments seem to show that the yield of glucose from the leaves varies at different times of the year, within only narrow limits :—

November, 1905.—100 parts by weight of the leaves yielded glucose 5 parts by weight.

November 16th, 1905.—100 parts by weight of the leaves yielded glucose 4.7 parts by weight.

November 27th, 1905.—100 parts by weight of the leaves yielded glucose 4.1 parts by weight.

December 6th, 1905.—100 parts by weight of the leaves yielded glucose 4.8 parts by weight.

April 20th, 1906.—100 parts by weight of the leaves yielded glucose 5 parts by weight.

June 7th, 1906.—100 parts by weight of the leaves yielded glucose 4.7 parts by weight.

Although the results of the work on the chemistry of the leaves are inconclusive and unsatisfactory, a number of physicians have found preparations of violet leaves to be active.

The best form in which to present the drug is in a fresh infusion, the only objections to which are the large dose necessary to be taken, and the difficulty of getting a supply of fresh leaves all the year round. Failing this, a solution may be prepared by exhaustion with alcohol, and subsequent removal of the greater part of the spirit.

I described the method of making such a preparation fully in my former paper.

Some objection has been taken to the amount of alcohol in it, but up to the present I have been unable to substitute any other preservative which is satisfactory.

(*a*) Read before the Therapeutical Society on October 30th, 1906.

NOTES ON A CASE OF ACUTE YELLOW ATROPHY OF THE LIVER. (*a*)

BY F. H. EDGEWORTH, M.B.CANTAB., D.Sc. LOND.

Professor of Medicine, University College, Bristol; Physician to the Bristol Royal Infirmary.

ACUTE yellow atrophy of the liver is such a rare disease that individual cases are worthy of publication. The following is the only instance which has occurred at the Royal Infirmary in the last eighteen years.

A woman, æt. 40, attended the out patient department on July 8th last, complaining of nausea, anorexia, and occasional vomiting for the preceding week. She had never had any serious illness, and had never been jaundiced before. She had drunk a fair quantity of beer. She was found to be slightly jaundiced, with a normal temperature, a good pulse of 90 per minute, no arterio-sclerotic changes, normal heart and lungs. The vertical extent of hepatic dulness was normal, reaching to the costal margin in the right nipple line. Nothing wrong was detected on palpation of the abdomen—no tumour or distended gall-bladder, or enlarged spleen. A diagnosis of catarrhal jaundice was made. Salicylates and saline purgatives were ordered.

On July 14th, one week later, she again attended. The nausea and anorexia were better, but the jaundice still persisted. The urine contained bile pigments but no albumen.

On July 20th, she felt sick again, had pain in the abdomen, and vomited repeatedly; on the following morning she gradually became comatose, and was admitted to the Infirmary about 11 a.m. I saw her at 12 o'clock. She was in a semi-comatose state, with clenched teeth, equal pupils slightly reacting to light, and moving a little when the skin was sharply pinched. The skin of a faint orange colour, was sweating profusely,

(*a*) Read at a meeting of the Bristol Medico-Chirurgical Society, January, 1906.

and the temperature was 99° F. The pulse was regular, of low tension, 134 per minute. The apex of the heart was ¼ in. internal to the left nipple line, and no added sounds were present. The lungs were clear down to the bases. The abdomen was flaccid, no enlarged subcutaneous veins were visible. No ascites, or tumour, or other abnormality was discoverable. The spleen was not enlarged. The vertical extent of the hepatic dulness was 2½ in. in the nipple line, the lower edge being a finger's breadth above the costal margin. The urine—a catheter specimen—was bile-stained, acid in reaction, sp. gr. 1023, and contained a fair amount of albumen; it deposited numerous bile-stained granular casts, but no leucin or tyrosin crystals; it contained 2 per cent. of urea.

There was no œdema of the legs; these and the arms were equally and perfectly relaxed. The knee-jerks were equal and exaggerated. There were some doubtful purpuric spots on the arms and legs. The fundi of the eye were pale, with normal vessels, and the optic discs were of a primrose-yellow colour. The patient was given 5 grs. of calomel in a nasal feed. At 3.30 the same afternoon she had a convulsion; twitchings began in the face and spread all over the body. At 5.15 p.m. she had another, and at 7 o'clock a third, in which she died.

On reviewing these phenomena, it would appear that the patient had jaundice for a fortnight, preceded by some gastro-intestinal symptoms; then coma of sudden onset, followed by convulsions, and death within nine hours of its onset. With these symptoms it was found that the liver had slightly diminished in size and that albumen had appeared in the urine.

At the *post-mortem* examination it was found that the brain, heart, lungs, abdomen, and spleen were normal. The uterus was slightly increased in size; it contained no fœtus or evidence of pregnancy. The kidneys were a little enlarged; they peeled well, and presented no naked-eye abnormality. The liver was considerably reduced in size and weighed only 32 oz.=⅓rds of normal; it was very flaccid; the capsule, which could be peeled off, was loose and wrinkled; the substance of the liver was of a mottled yellow and red colour, and no normal hepatic tissue could be seen. The bile-ducts were patent and contained no gall-stones. No evidence of phosphorus was detected on distilling portions of the stomach and intestines and their contents in the dark. On microscopical examination it was found that the cardiac muscle-fibres showed some pigmentary degeneration—a change probably quite independent of the fatal disease. There was extensive granular degeneration of the cells lining the convoluted tubes of the kidneys and desquamation of the cells lining Bowman's capsules. This was the cause of the albuminuria and tube-casts in the urine.

In the areas of yellow atrophy in the liver the hepatic cells were granular and their nuclei were hardly visible. The epithelium lining the smaller bile-ducts was proliferating. Round the bile-ducts and vessels in the portal spaces there was some increase of fibrous tissue—due no doubt to the patient's alcoholic intemperance. In the areas of red atrophy the hepatic cells had altogether disappeared. The microscopical examination thus showed evidence of acute necrotic degeneration of the liver cells, with a small amount of cirrhosis. The same poison (? of bacterial origin) which destroyed some and damaged others of the hepatic cells also damaged the secreting cells of the kidneys.

The clinical manifestations of this case were almost, but not quite, typical of the condition. As usual, there was nothing to distinguish the first stage from ordinary catarrhal jaundice. The terminal stage was a little exceptional in that there were no signs of cerebral irritation—headache, restlessness, delirium—preceding the coma; the symptoms were abdominal pain and vomiting. No leucin and tyrosin were found in the urine; but it would seem that these substances are absent in about a third of published cases. The case, unfortunately, does not shed any light on the causation of this obscure disease. What the poison was, where it was produced, how it affected the brain, whether it accumulated in the body owing to its damaging the renal tissue, are all unknown.

OPERATING THEATRES.

NORTH-WEST LONDON HOSPITAL.

Fracture of Both Patellæ at an Interval of Six Years.—Mr. Jackson Clarke operated on a woman, æt. 45, who had been admitted for fracture of the right patella. Five or six years previously she had broken the left patella, and had been treated in a London hospital, where the fragments were wired soon after the injury, but at the present time there was a slight interval between the fragments of the left patella, and the presence of this interval was explained by the patient as being due to the wire having been broken when the joint was first moved after the operation. In spite of this interval there was firm fibrous union, and the knee-joint was quite serviceable. The cause of the fracture was the same in both instances—the patient having tripped over some slight obstacle. The present fracture on the right side dated for some six months back, the patient's knee having "given way" suddenly and remained weak ever since, the woman being unable to walk; but she had no idea the bone was broken. She was pale, slightly built, and of middle height. The patient having been anæsthetised, a curved incision was made with its extremities at the sides of, and rather above, the patella, and its convexity crossing the front of the limb below the patella. The U-shaped flap was turned up, revealing the two fragments separated by a depressed interval of two inches. The broken surfaces of the bone were covered, the upper by a thin layer of aponeurotic tissue (the remains of that which had originally stretched over the front of the patella), and the lower by a layer of newly-formed cicatricial tissue over one-eighth of an inch in thickness. In clearing the fractured surfaces, the thin layer of aponeurotic tissue was removed from the upper fragment, whilst that covering the lower was dissected up from the deep towards the superficial surface, where it was left attached. The fractured surfaces of both fragments were then scraped until the cancellous bony tissue was exposed. The fragments were then perforated, each at two points, by a grooved perforator which greatly facilitated the passing of the wire. The wires were then tightened, and the flap attached to the lower fragment was used to cover the line of union of the two bones, which were next closely apposed. When the wires had been cut short the twisted portions were hammered down into this same fibrous flap. Stretch-

ing over the front of the joint, Mr. Jackson pointed out, was a thin sheath of slightly vascular cicatricial tissue, which quite shut off the joint cavity; this tissue was left undisturbed, since it prevented any blood or exudation from entering the joint. Nothing more remained but to close the wound, which was done by a few fine catgut stitches, the angles being left open for the insertion of two small tubes, which it was intended to leave in for twenty-four hours. Mr. Clarke said that the subject of wiring a fractured patella presented many points of interest. The first question was whether the operation gave results that were distinctly better than those of the non-operative treatment—*i.e.*, that by splints and bandages. He himself had no doubt that the results were distinctly better after careful wiring of the fragments because a firm union was obtained with a practically normal patella. This seldom resulted from the old treatment without operation. The second point to consider was the risks of the operation, and in this connection he strongly emphasised the importance of waiting for at least five days after the occurrence of the fracture before opening the joint; this interval allowed the damaged tissues to accommodate themselves to the presence of the blood and torn ligaments in the joint and between the fragments of bone, and after this interval, if the joint was opened with every precaution against sepsis, the risk of infection was extremely slight; but when it is remembered how awful the results of septic infection are in the knee-joint, it must be realised that no single precaution against sepsis must be relaxed. The incision Mr. Clarke had adopted in this case he said he preferred on account of its giving more complete access to the parts than does a lateral incision, and at the same time the skin incision was completely removed from the line of union of the bones. Mr. Clarke also remarked that the cicatricial flap that was used to cover the line of union between the fragments served the double purpose of making a bed for the twisted ends of the wires and of assisting nature in the formation of the new periosteum. The sheet of new tissue that closed the front of the joint, he pointed out, was in this particular case not attached to the patella, but stretched from the synovial tissue above and below its limits, hence it was not necessary to open the actual joint cavity. The dressing, he said, consisted of double cyanide gauze wrung out in 1 in 40 carbolic lotion, and this was covered by a small piece of jaconet to spread the exudation in the dressing and to prevent it coming through the bandages at one point as it often does when bones have been operated on and this precaution is omitted. The limb was put on a light malleable tin back splint, after the latter had been moulded by the hands to suit the contour of the patient's limb. The post-operative course in this case has been absolutely normal. The house surgeon Mr. Ferguson) having removed the tubes on the day after operation, the temperature remained normal. It is Mr. Clarke's intention to begin slight passive movements of the joint a fortnight from the date of the operation and to increase them gradually.

AN examination of candidates for not less than thirty commissions in the Royal Army Medical Corps will be held on January 24th and following days. Applications to compete should be made to the Secretary, War Office, not later than January 14th, on which date the list will be closed. Candidates who are over the regulated limit of age at the date of examination will be permitted to deduct from their actual age any period of service in the field after October 1st, 1899, that they could reckon towards retired pay and gratuity if such deduction will bring them within the age limit.

TRANSACTIONS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON.

MEETING HELD OCTOBER 26TH, 1906.

The President, Mr. CLUTTON, in the chair.

MR. DOUGLAS DREW showed a case of

TRAUMATIC CEPHALHYDROCELE IN A FEMALE BABY ÆT. SIX WEEKS TREATED BY OPERATION.

The infant was admitted to the hospital within a few hours of the accident with a large swelling upon the right side of the head. There had been no loss of consciousness. For two days after admission twitching was noticed in the left arm and leg, and there was distinct impulse in the swelling when the child cried. The tumour gradually increased in size, and the gap in the bone became much wider—*i.e.* about half an inch. At the operation the sac containing the cerebro-spinal fluid was found to be formed of the separated periosteum. On allowing the fluid to escape profound shock ensued. The fracture was 1½ inches long, situated horizontally in the parietal, and measured half an inch across, and through the centre of the opening a hernia cerebri protruded. Owing to the condition of the child no attempt was made to suture the dura; both the bones were forcibly drawn together with silver wire, the hernia cerebri cut off, and the periosteum replaced and scalp wound sutured.

Mr. GODLEE commented on the rarity with which success followed operation in such cases, and congratulated Mr. Drew

Mr. CHARTERS J. SYMONDS showed

A CASE OF TRAUMATIC SEPARATION OF THE HEAD OF THE FEMUR.

Boy, æt. 16, fell from a tree early in 1904. Resumed work in three days. After six months had pain, and from that date has done very little work. The present condition showed shortening of the neck of the femur. Some limitation of movement. The skiagram showed that the head of the femur has been separated.

Mr. W. WATSON CHEYNE showed

MALUNITED FRACTURE OF BOTH BONES AT THE ANKLE JOINT.

Patient fell on July 25th, 1903, and twisted his left leg under him. The result was a bad fracture through base of internal malleolus and part of fibula at a higher level.

January 5th, 1904.—Admitted to King's College Hospital with very marked angular deformity, the leg being turned inwards just above the ankle, forming an angle of 150 degrees with the leg above it. The foot was also rotated inwards, and the patient walks on the outer border of the foot. Shortening of left leg.

January 13th, 1904.—Two lateral incisions made. Muscles and periosteum stripped off, and the bones which were fractured obliquely divided along the line of fracture. The fragments of the tibia were fixed together by an aluminium plate and tacks. The sharp end of the upper fragment of the fibula was inserted into the medullary cavity of the lower fragment, and thus the bones were kept in firm apposition without any wire.

Mr. T. H. KELLOCK showed a

CASE OF DEFORMITY OF THE LONG BONES.

The patient, a girl æt. 8. When aged three she was seen on account of slight genu valgum, and a few months after for greenstick fracture of the bones of the left forearm. About a year ago the left radius and ulna were again broken as the result of a fall from a chair. The deformity of the bones of the legs was now very great; there was very marked genu valgum, and the feet were strongly inverted as the result of curvature outwards at the lower ends of the tibiæ and fibulæ; the femora were a good deal curved in a forward and outward direction. In the upper limbs there was bending about the middle of the radius and ulna on both sides, although there was no history of fracture on the right side. At the upper ends of the humeri a

marked thickening and interior curvature was noticeable. Skiagrams of the bones showed that the chief part of the deformity is apparently due to fractures and irregular ossification occurring at short distances from the epiphyseal lines.

Dr. Garrod discussed the significance of the transverse lines seen above the epiphysis in the skiagram.

The President considered the affection to be one of rickets, although it was still progressing. He thought that many cases of fragilitas ossium were due to late rickets.

Mr. T. H. Kellock also showed a

CASE OF SYMMETRICAL AFFECTION OF THE HIP JOINTS.

Boy, æt. 8. The patient, when seven weeks old, had had a severe illness which was said to be dysentery, after which the right knee became very swollen and remained so for about two months, when it got quite well. He did not walk until eighteen months of age. About a year ago it had been first noticed that his gait was peculiar, but he had never complained of any pain in the hips and had not been laid up. Now he had a peculiar gait rather resembling that in congenital dislocations; the trochanters, especially the right, were raised, and appeared prominent when the legs were adducted. There was no pain nor tenderness, and the movements of the joints were free.

Mr. Warren Low compared the case to those of septic arthritis that occurred after adult dysentery, and which were often of long duration.

Mr. Percy Northcote and Mr. A. M. Gossage showed

A CASE OF PARTIAL HEART-BLOCK.

The patient, æt. 58. He had had syphilis at the age of twenty-one, but had otherwise been healthy until four years before, when he had a sudden attack of unconsciousness. Since then he has had numerous similar attacks. The attacks are either a momentary giddiness, or at other times complete unconsciousness for several seconds. On examination the arteries were found to be much thickened, the systolic blood-pressure being equal to 178 mm. of mercury. The urine generally contained a small quantity of albumen. When first seen the ventricles were beating at 68, but the patient suddenly felt slightly giddy, and the rate dropped to 32—*i.e.* to about the half of the former rate. As a rule the pulse-rate was 30. Observation under the X-rays showed that the auricles were beating at double the rate of the ventricles, and the bradycardia was probably due to depression of conductivity in the bundle of His between the auricles and ventricles. The more severe attacks were associated with the non-conduction of a series of auricular beats to the ventricle; for instance, in one attack no sound was heard over the heart for five seconds. In the tracing shown the interval between two successive ventricular beats was also about five seconds.

Dr. Alexander Morison discussed the sphygmogram in the case.

Mr. Gossage said that the intermediate sounds that were sometimes heard—they had not been heard in this case—were due either to extra systolic ventricular contractions or to auricular systole. They were very difficult to time.

Mr. Edred M. Corner showed

A CASE OF (?) SYPHILITIC DISEASE IN THE BONES OF ONE LIMB.

Girl, æt. 7, was noticed thirteen months ago to limp whilst walking. On August 2nd she came to St. Thomas's Hospital, when it was found that the right leg was 2½ inches shorter than the left. The upper section (from anterior superior spine of the ilium to lower end of femur): Right side, 9¾ inches; left side, 11¾ inches; difference 2 inches. The lower section (length of tibiæ): Right side, 7½ inches; left side, 8 inches; difference ½ inch. The shafts of the right femur and tibia were thickened, particularly at their upper and lower ends. The bones had an ill-defined surface, and in their internal structure presented a vacuolated appearance. The disease affects chiefly the epiphyseal ends of the shafts of these bones.

Dr. H. G. Turney showed

THREE CASES OF PATENT DUCTUS ARTERIOSUS WITH ARTERIO-VENOUS MURMUR.

The patients, who were all female, were of the age of 20, 29, and 31 respectively.

Dr. Charles Box suggested that the systolic part of the murmur might be due to ventricular contraction and the diastolic to arterial.

Dr. Ewart thought that two of the cases might possibly be due to pulmonary stenosis, the diastolic part of the continuous murmur being due to aortic regurgitation.

Dr. Frederick Taylor agreed with Dr. Ewart. Even when a patent ductus arteriosus was present, no continuous murmur might be heard.

Dr. Turney said that a continuous murmur occurred, apart from a patent ductus arteriosus, only with an aneurism leaking into a venous trunk or with an infective arteritis doing thus. Both these latter conditions could be excluded in this case.

Sir Hugh Beevor showed a case of

LARGE CYSTIC ABDOMINAL TUMOUR, PROBABLY OF RENAL ORIGIN.

Boy, æt. 16. Symptoms of mechanical interference only. Blood normal. Condition stationary for twelve months. Dyspnœa, first noticed two years ago.

Mr. R. J. Godlee showed a

CASE OF DOUBLE COXA VARA.

The patient was a boy, æt. 16, who stated that, though he always turned his toes out, he was active and could play games up to August, 1905, when a barrow fell against him and broke his right thigh. The right great trochanter was more prominent than the left, and was three-quarters of an inch above Nélaton's line. Both limbs were rotated out; abduction, flexion, and rotation in were much limited. Walking was difficult; the gait was that common in cases of coxa vara. Skiagrams showed double coxa vara, with possibly fracture of the neck of the right femur.

Mr. H. C. Semon (introduced by Dr. J. Rose Bradford) showed

A CASE OF XANTHOMA, WITH ENLARGEMENT OF THE LIVER.

The patient, a widow, æt. 60, was admitted to University College Hospital with the history that for seven years she had had jaundice. Two years ago numerous yellow masses developed on the limbs and body. The liver also was found to be enlarged, and laparotomy had been performed in the Sussex County Hospital. The organ was found to be indurated and scarred, and numerous enlarged glands were felt in the abdomen, along the spine, and in the portal fissure. At the present time the liver was much enlarged. The yellow nodules of the skin were in some cases movable, but in others appeared to be fixed in a varying degree to subjacent periosteum or bone.

Mr. H. C. Semon also showed

A CASE OF ACROMEGALY.

The patient, æt. 27, had suffered pain for three years in the left side of her face and cranium, occurring in paroxysms. The hands and feet had been gradually increasing in size during the last eight months. Besides the alteration of the hands and feet, the nose and tongue were enlarged. There was also well-marked bi-temporal hemianopsia, and both discs showed evidence of optic atrophy. Oblique illumination of the nasal half of the left disc produced only sluggish contraction of the left pupil. The urine showed a trace of albumin occasionally.

Mr. D. C. L. Fitzwilliams (for Mr. C. A. Ballance) showed

CHILD FROM WHOM A CEREBELLAR TUMOUR HAD BEEN REMOVED.

The patient, then æt. 4 years and 10 months, was admitted to the Hospital for Sick Children under the care of Dr. Colman in May, 1905, with symptoms of cerebellar tumour. An operation was performed by Mr. Ballance in June, 1905, and a large tumour (which was shown) was removed from the cerebellum. The child made a good recovery.

Dr. A. E. GARROD showed

A NEW CASE OF ALKAPTONURIA.

The patient was a girl, æt. 3. Her parents were not blood relations, and there were no other known cases in their families. The patient was an only child. Alkaptonuria was much rarer in females than in males, and only six or seven congenital cases in females had hitherto been recorded out of a total of about forty congenital cases. The child came under Dr. Still's observation as an out-patient on account of the appearance of her urine and the staining of clothing by the urine, which was noticed on the second day of life. The urine darkened on exposure to air, darkened conspicuously with alkalies, and yielded a transient blue colour with dilute ferric chloride solution. It reduced Fehling's solution with the aid of heat, and ammoniacal silver nitrate in the cold. It was optically inactive.

THE SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

MEETING HELD AT 11, CHANDOS STREET, ON OCTOBER 19TH.

MR. W. MILNER BURGESS in the Chair.

DR. T. R. WHIPHAM showed a case of osteoarthritis in a girl, æt. 13, beginning last Christmas in both wrists and hands, and affecting later the knees and ankles. There was enlargement about the ends of the bones and swelling of the synovial membranes. The spleen was not enlarged, nor were the lymphatic glands, with the exception of a solitary gland in the left axilla. There was no family history of rheumatism or any joint affection in the family. The case was illustrated by skiagrams showing no obvious change in the bones or cartilages, the swellings being apparently in the synovial membranes and tissues around.

Dr. T. R. Whipham showed a girl, æt. 15, who was the subject of numerous deformities. The bones of the left side of the face were ill-developed, and there was deformity of the left pinna. The arch of the palate was high; the left shoulder was elevated; the arm shorter and with less muscular development than its fellow. Gaps could be felt in the second and fourth ribs. There were lateral curvatures of the spine in the cervical and upper dorsal regions. The left scapula was deformed and rotated inwards, and the muscles of the shoulder-girdle shortened, producing torticollis.

Dr. T. R. WHIPHAM showed a baby (female), æt. 10 months, with a congenital malformation of the heart. There was cyanosis and clubbing of the fingers and toes. The right side of the heart was enlarged, but no definite murmur was heard, though the first sound was a little soft. A striking feature was the great polycythæmia. In September the red cells numbered 12,900,000 per c.mm., with 150 per cent. of hæmoglobin, and the leucocytes totalled 12,000. This is the highest count that the author could find recorded in the literature.

Dr. WHIPHAM considered that probably atasia of the pulmonary artery was present.

MR. MILNER BURGESS showed two cases of hypospadias in brothers. In one child at birth there were three openings, one at the meatus and two in the penile urethra, and through the lowest opening a probe could be passed into the bladder. The second case was very similar. It was discussed whether the sexual function could be satisfactorily performed, and also when any operation should be performed, some writers favouring an early operation, and others deferring such proceeding till adult life.

MR. P. LOCKHART MUMMERY showed a child, æt. 7, somewhat lacking in intelligence, who since birth has been unable to supinate either forearm. The hands were in the position of pronation, and the amount of rotatory movement at the wrist is very small. An X-ray photograph was shown, and a discussion ensued as to its signification, whether the radius was normally developed or no, and, if the former, whether the condition was not due to spasm of the pronators secondary to a weakening of the supinators.

MR. H. S. CLOGG showed a case of bilateral congenital sinuses of the lower lip. The child was the fifth of the family, the other members showing no deformity. It was born with a severe degree of bilateral complete harelip and cleft palate. On the upper margin of the lower lip on either side of the mid line is a papilla, surrounded on the oral aspect by a groove. A sinus leads from this groove into the lip to just beneath the mucous membrane. The sinus is ¼ inch long. The two sinuses converge, but do not meet.

DR. ALEXANDER MORRISON showed a case of persistent arhythmia of the heart, a boy æt. 8. He had a neurotic history, and had had a severe attack of measles in 1904. There has been a persistent allorrhythmia, characterised by the occurrence at intervals of an extra systole and a long pause. At the moment of intermission there is a pulsation in the right internal jugular vein, and this wave coincides with the ventricular extra systole, as is seen in simultaneous tracings. There is no inconvenience to the child.

DR. L. GUTHRIE showed a case of anterior poliomyelitis of the fifth cervical segment of the cord, simulating Erb's type of paralysis. The boy, æt. 3½, showed atrophy and paralysis of the right deltoid, biceps, brachialis anterior and supinator longus The supra and infra spinati were only slightly affected. The supinator brevis escaped. The clavicular portion of the pectoralis major was wasted. Division of the fifth cervical nerve and grafting the distal end into the sixth nerve was suggested. The disease ensued on the opening of a small abscess in the right mastoid region when 13 months old.

MR. G. PERNET showed a case of multiple lupus vulgaris in a boy of 5. The disease had been present for two or three years. There were three foci of the disease, on the elbow and face.

DR. G. A. SUTHERLAND showed a boy, æt. 6, the subject of habit spasm. It began by movements of the face in December last year. These movements have continued and others developed. The movements consist in (1) blinking the eyes; (2) twisting the mouth; (3) jerking out the tongue; (4) jerking the head; (5) jerking the right shoulder; and (6) occasionally throwing out his legs and arms. In addition he makes curious laryngeal sounds at times. There is no history of rheumatism or chorea. He has been ordered glasses for hypermetropia. The condition has persisted 10 months, and shows no improvement.

DR. J. PORTER PARKINSON showed two cases of anæmia pseudoleukæmia infantum. The first case, a boy, æt. 20 months, had been treated since May by fresh air, iron, arsenic, etc., while the X-rays were applied three times weekly over the spleen. Great improvement resulted; the spleen diminished to a quarter of its original bulk, and the blood count, which had been markedly altered, became nearly normal. The general condition also had much improved

The second case was a child of the same age, and had been treated in an exactly similar way, the X-rays being omitted. In this child there was no improvement either in the general condition or the anæmia, nor did the spleen diminish in size.

MR. SYDNEY STEPHENSON showed a child, æt. 6½, showing a curious deformity of the eyelids. The palpebral fissure was directed downwards and outwards, exposing more of the eyeball than is customary. The eyelids could be closed voluntarily. There was no trace of the lower puncta lacrymalia. The lower part of the orbit was felt rough and unfinished owing to lack of parts of the malar bones and orbital processes of the superior maxillary bones. The only associated deformity was a diaphragm occluding the left external auditory meatus.

DR. C. O. HAWTHORNE showed a case of cerebral diplegia in a boy, æt. 5 years. The spastic condition was most marked in the right lower limb, but exaggerated knee-jerks and extensor responses were present on both sides. The left upper limb was approximately normal, and the right showed clumsiness of movement rather than spasticity. The boy did not talk, but

appeared to understand all that was said to him. The fundi of the eyes were normal, and the boy had never had any fits. He was a first-born child, born at full term with the use of instruments.

Dr. Hawthorne also showed a child having a coloboma of the iris, choroid and optic disc, and an infant with an extreme depression of the left half of the frontal bone, attributed to the use of forceps during delivery.

HARVEIAN SOCIETY.

Clinical Meeting held on Thursday, October 25th, 1906, at St. Mary's Hospital.

Dr. F. W. Clark, President, in the chair.

The following cases were shown:—

1. Dr. Sidney Phillips. (1) A case of Dextrocardia. (2) Congenital heart disease in a girl æt. 18. There was deep cyanosis present since birth, with marked clubbing of the fingers. No cardiac murmurs were present. He considered that the probable lesion was, absence of the inter-ventricular septum. Dr. John Broadbent and Dr. Maurice Squire discussed the case and agreed with Dr. Phillips as to the cause of the condition, and the latter related a recent post-mortem experience confirmatory of this.

2. Mr. Jackson Clarke showed three cases of congenital hip disease in children æt. 3, 3, and 3½ respectively, completely cured by operative treatment and exercises, and a fourth case in which the dislocation had been cured by operation; all that was now required was treatment by suitable exercises to relieve the abduction resulting from fixation in the abducted position.

3. Dr. Scanes Spicer showed a case of inoperable cancer of the throat, which had greatly benefited from injections of a vaccine of micrococcus neoformans.

Mr. Jackson Clarke, Mr. Spilsbury, Dr. Hill, Dr. Eastes and the President discussed the case.

Dr. Spicer then demonstrated a method of direct examination of the trachea and bronchi, or œsophagus, which was of great service in the removal of foreign bodies.

4. Mr. Parry Morgan, for Dr. Luff, showed a case of a large rounded tumour in the epigastric region of three months' duration in a man æt. 54, which appeared to be a carcinoma of the stomach. There had been sickness and pain, but now he was able to take food without discomfort.

Dr. Willcox stated that examination of the stomach contents showed the absence of free hydrochloric acid and the presence of a quantity of mucus, and considered that it was mainly the muscular coat of the stomach which was affected. Dr. John Broadbent thought that the growth might possibly be a sarcoma.

5. Dr. Willcox, for Dr. Luff, showed a case of copper poisoning in a man. The patient had had vomiting and abdominal pain, and when admitted there was a well-marked deep blue line on the gums and slight tremor of the hands. He had found copper and zinc in the urine and fæces. The patient had been doing a lot of brass polishing recently, and apparently must have been careless about cleaning his hands and been poisoned by brass, which is an alloy of copper and zinc. This appeared to be the only possible source of poisoning. Dr. Lamb and Dr. Eastes discussed the case.

6. Dr. Langmead, for Dr. Harris, showed (1) a case of pseudo-bulbar palsy. The patient was a man æt. 34, who eight weeks ago suddenly lost his voice and had some weakness of the right side and a coarse tremor of the right arm when excited. There was no obvious wasting of the tongue or paralysis of the soft palate, and he could swallow well. He could at times speak several words of intelligent speech in a whisper. Dr. John Broadbent considered that the case might be functional; the loss of voice was aphonia rather than aphasia, and came on suddenly; the tremor only appeared when the man was excited, and from the character of the symptoms it was difficult to trace them to any definite organic lesion.

(2) A case of tumour of the right optic thalamus in a man æt. 24. There was loss of power in the left arm and leg of five weeks' duration, blindness of the left lower quadrant, with headache, vomiting and optic neuritis.

Dr. John Broadbent showed a specimen of aneurysm of the aorta, which compressed the superior vena cava and had caused paralysis of the left vocal cord. The patient, a man æt. 49, who was to have been shown, had died suddenly five days before from rupture of the aneurysm.

GLASGOW MEDICO-CHIRURGICAL SOCIETY.

Meeting held October 19th, 1906.

The President, Dr. Lindsay Steven, in the Chair.

The President referred to the great loss the Society had sustained by the death of Dr. James Finlayson.

Dr. J. Galbraith Connal showed several patients who had suffered from diseases of the nasal cavities and mastoid disease, of which we hope to publish particulars in our next.

Dr. Alex. McLennan gave an excellent demonstration of

Spirochætes from Syphilis, Yaws and Granuloma Pudendi,

and remarked that the probability of the spirochæta pallida being the cause of syphilis had been advanced somewhat by recent research. The serum from an eight months syphilitic had been found to possess at least a feeble agglutinating power over the spirochæta pallida, and also to still the movements of the living organism. Healthy serum does not do this. The organism has been found in congenital syphilis in numbers usually corresponding to the severity of the lesions. The further discovery of spirochætes on the skin of congenital syphilitics, apart from any local lesion, is important. Histologically the spirochæta pallida is found to inhabit the deeper structures rather than the immediate surface. It has also been demonstrated in countless numbers in sections of the congenital manifestations. These facts, while apparently supporting the view that the pallida is the cause of the disease, require some sifting. If this be so, then the view that the congenital type is only feebly contagious is unwarranted. Syphilis for its spread does not depend upon the congenital, but upon the surface discharges from the acquired lesions. In those the pallida is more evident in the deeper parts, and is admittedly scanty in the surface discharge. In the discharges from the primary and secondaries of the acquired disease numerous small protoplasmic bodies are found. They may be seen in some instances to have flagella, in others to be without. In a recent article in the *British Medical Journal* I have sought to show the relationship between these and the spirochæta pallida, which, while not being the cause of the contagion, may have something to do with its lesions, and is indeed part of the life cycle of the infecting organism. It is necessary to differentiate these organisms from artefacts, deposits of stain, and from protoplasmic buds from the tissue cells or from nuclear débris. Such buds I have found present in all smears from lymphatic glands enlarged from whatever cause. When, however, hordes of feebly staining bodies varying in size and shape are present in the surface discharge, the probability of their being protozoal becomes stronger.

The spirochæte found in yaws is, as already pointed out by Castellani, almost identical with the pallida, while those found in granuloma pudendi are more delicate, more closely waved, and very much longer and more difficult to stain.

The L.S.A. Diploma of the Society of Apothecaries was granted last week to the following candidates, entitling them to practise medicine, surgery, and midwifery:—C. F. W. Dunn, E. L. D. Gay, and G. M. Seagrove.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Oct. 28th, 1906.

CAUSES OF FACIAL NEURALGIA.

BERNHARDT defined facial neuralgias as "painful conditions seated in the sphere and territory of the sensitive branches of the tri-facial," which would mean that not only do the trunks of the branches and the nerve filaments suffer, but also the plexus of anastomosis with the facial nerve, and even the sensitive branches which ascend more or less the motor nerve. Consequently, it is natural to distinguish facial neuralgia properly so-called and neuralgia of the plexus of the face.

The frequency of neuralgia of the face is rather difficult to appreciate. According to Valleix, Eulenberg, Lachnit, neuralgia of the trigemini is the most frequent. Conrad and Bernhardt give the precedence to sciatica. Giurac thinks it less frequent than intercostal neuralgia and sciatica. The right and left side are about equally affected, and generally the pain is limited to one branch, although Valleix maintains that such is not the rule, that nearly always lancinating pains are felt in the two other branches of the trigemini.

Neither are authors agreed as to the sex. According to Chaponnière the two sexes are equally affected.

Cold, humidity. Sudden atmospheric changes play an undoubted rôle in the genesis of facial neuralgia and in the recurrence of the attacks. Certain *professions* predispose to facial neuralgia; it has been frequently observed in *cooks*. Emotions are frequently incriminated by the patients, and as a predisposing cause they cannot be denied.

In order to trace the true cause of facial neuralgia, two forms, says M. Levy, who has made a special study of the subject, must be distinguished: facial or minor neuralgia, and neuralgia of the gasserian ganglion, to which he gives the name of major neuralgia.

Minor neuralgia is so called from its simple and well-known causes, from its short duration, and its prompt yielding to appropriate treatment.

Major neuralgia is more obscure in its ætiology, appearing to depend on the temperament and the constitution of the patient. It is characterised by long duration, tenacity, frequent relapses, and its resistance to medical and surgical treatment. This variety is frequently found in persons of advanced life, and has a neuro-arthritic origin. Minor neuralgia invades frequently the first branch of the tri-facial, but can also affect the other two. The irritating agent which provokes it can have its seat on the whole course of the fifth pair.

The exciting cause may be found in the mouth, the nose, the eye, the ear, the face, etc.

Ancient authors were slow to admit the dental origin of neuralgia, but modern authors insist on the frequency of facial neuralgia due to lesions of the teeth. It can be the consequence of a physiological phenomenon, *eruption*. M. Ferrier observed several cases provoked by the piercing of the wisdom tooth, which is frequently accompanied with ulceration of the gum, or where the organ still enclosed in the maxillary bone tries to make its way out in the narrow space between the second molar and the ascending branch of the bone. In aged persons, the exaggeration of another physiological phenomenon produces the same results. The pulp, as is known, diminishes in volume in the aged, while the surrounding ivory develops considerably. It happens thus that in arthritic patients the pulp undergoes a process of calcification and compresses the nerves. Other dental causes are: caries of the teeth, periostitis, diseased roots and obturation of the caries without sufficient disinfection of the parts.

The nasal origin of facial neuralgia, a long time denied, is admitted to-day. Primary or secondary inflammations of the mucous membrane of the nasal cavities and of the sinuses provoke the malady, especially if the frontal sinuses are touched (supra-orbital neuralgia).

Superficial inflammations of the eyes (conjunctivitis, iritis, irido-choroiditis) can be accompanied by neuralgic pains. The same may be said of glaucoma.

Catarrh of the middle ear and its cavities is rarely a cause of neuralgia. But external lesions, eczema, suppurations have frequently been exciting causes.

Lesions of the trunks of the nerves are important factors of neuralgia. They are either intrinsic; traumatism with contusion of the nerve, compression by lymphatic ganglions, fibroma, cancer; or intrinsic: sclerosis of the arteries of the nerve, varicose condition of the veins, tumours, neuroma.

The trigemini may be irritated at the seat of Gasserian's ganglion, by exostosis, caries of the petrous portion, neo-formations of syphilitic or tuberculous origin compressing the ganglion and the roots of the tri-facial. Besides these exciting causes might be mentioned neuritis consecutive to certain acute infections (grippe, erysipelas, measles, typhoid fever, pneumonia), or chronic, of which the principal are: tuberculosis, syphilis, malaria. This latter is one of the best established causes of facial neuralgia.

If minor facial neuralgia is an accidental malady, it is not so with the major form, in which heredity plays an important rôle, and it can be said it is part of the pathological baggage of the neuro-arthritic family.

GERMANY.

Berlin, Oct. 28th, 1906

IN the Pathological Section of the Naturforscher-versammlung, Professor Baumgarten, of Tübingen, spoke on new experiments on the

PASSIVE IMMUNISATION FOR TUBERCULOSIS.

From his own observation on calves, passive immunisation was possible, but not under all conditions, and for this reason he had returned to active immunisation. In contrast to Behring, he considered subcutaneous injection advisable. He was able to set up tuberculosis of the lymph glands through the blood track, and from that he concluded the probability of the transmission of tuberculosis before birth.

Bartel (Vienna) found from his own experiments that tubercle bacilli settled within places where they found but few resistant cells.

Henke (Charlottenburg) in some cases found the starting-point of the disease to be the digestive track.

Dr. Westenhoffer (Berlin) spoke on the present state of our knowledge of

INFECTIOUS CEREBRO-SPINAL FEVER.

He said his investigations had culminated in the facts discovered that the cocci of the disease did not first of all infect the nasal mucous membrane, and from there reach the brain; but first of all the tonsils, and then the posterior wall of the fauces, from whence the invasion of the brain took place. It now remained to find out the carriers of the cocci.

Herr Jehl (Vienna) did not think that epidemics of the disease were sufficiently explained either by intermediary carriers or the conditions of dwelling-houses. It was not the common dwellings of the patients that was decisive, but common work-places. A thorough supervision of miners was an indispensable preliminary in the campaign against the disease. Workmen from infected mines should not be allowed to work elsewhere until it was ascertained that they were not carriers of cocci or that during the epidemic they had not stayed more than a day and night in the infected place. Transmission from child to child but rarely took place, as small children did not expectorate. In barrack epidemics immediate transmission from the diseased to the healthy could take place, as adults did expectorate. The reason why children were most frequently infected was that in them the tonsils were more largely developed. Children with very large tonsils were most frequently attacked. In the case of

adults dying of the disease, examination showed that they nearly all had especially large tonsils. Treatment up to the present had failed.

In the section for Hygiene, Professor Weber spoke on infection of the human subject by Perlsucht. There was a difference, in his opinion, between human and cattle tuberculosis, but cattle tuberculosis was transmitted as a food tuberculosis, and especially to children up to the 14th year. In Berlin he estimated that half the intestinal tuberculosis met with in children was due to cattle tuberculosis.

Frau Lydia Robinowitsch communicated the results of her recent experiments on tuberculosis, and concluded, as did Professor Weber, that cattle tuberculosis was communicable to man. She looked upon the occasional cause as the main factor for infection with this or that form of tubercle bacillus. Predilection on the part of the various excitors of tuberculosis for certain organs could be as little proved as a connection between the port of entrance or localisation to the tuberculous disease. Infection by food required the greatest consideration. Herr Zwick (Stuttgard) concluded that there was a separate cattle and human tuberculosis.

Professor Lehmann (Würzburg) spoke on the

Penetration of Industrial Material Poisons Through the Lungs and Skin.

Of the gases readily soluble in water, the workman takes in about 85 to 100 per cent. of the amount present. The admission into the system takes place altogether through the nose and mouth; scarcely any passed over the larynx, and that was when the gas was present only in small quantity. If the poisonous gases are carried direct into the lungs by a tube, the absorption is none the less, so that the deeper parts of the respiratory apparatus take up gases eagerly. In the case of carbon sulphide, about 22 per cent. is taken up. Poisonous gases are therefore to be excluded as much as possible. For many organic factory poisons, especially aniline and nitro-benzol derivatives, the uninjured human skin was specially absorbent. Cleanliness of the skin, the hair, the working clothes in work-places in which poisons are handled, should be looked after with the greatest care.

Dr. Brat was of opinion that the danger had become steadily less during recent years. Under ordinary conditions there were fewer accidents than formerly, and they were also of a slighter nature, but they were not excluded altogether. The buildings in which the businesses were carried on were more airy, and there were better arrangements for ventilation. Lehmann's view that poisons were absorbed to any extent through the skin was not in accord with experience, as the improvement obtained was entirely due to improvement in the atmosphere. In accidents happening, also, in the chemical industry, the diseases may almost always be traceable to breathing, although there was absorption through the skin. The question in actual practice was very different from what it was in the laboratory, and many laboratory experiments were misleading, such as that of the absorption of gases by breathing.

Professor Schottelius (Freiburg) spoke on preserved foods, and said that food that was recognised as bad should not be re-cooked or doctored by strong spices. Fresh food was better than all preserved food, so that the latter should be used as little as possible. German preserved foods were reliable. Some control over the age of the preserved food by the placing of some mark that need not be visible externally was desirable.

AUSTRIA.

Vienna, Oct. 28th, 1906

Chronic Influenza.

At the meeting for Internal Medicine, Kretz showed the lungs of a man æt. 56, who died after a very protracted illness. In 1900 the peritoneum began to fill with water, which was subsequently diagnosed as ascites following hepatic cirrhosis. This condition was followed by emphysema, ending in bronchiectasis.

The post-mortem confirmed the presumption of a bacterial origin, as the lungs, liver, and peritoneum were loaded with the germs. A thickening of the peritoneum and covering of the liver by the inflammatory process of the Influenza bacilli. The progress of the disease seems to have been slow, gradually creeping from the pleura to the peritoneum, where it lingered for years, extending back to 1900 for its origin, when the particularly severe influenza attack is recorded.

To confirm this hypothesis he recorded the history of several cases that occurred in 1897, which lingered for years and finally passed away with the same bacterial results. From these facts he endeavoured to establish this theory, that this chronic condition produced an immunity in the younger generation that made the recent epidemics impossible to occur in the future, as the resistance to infections would be higher, and thus destroy the pathogenic action of the bacilli.

Dilation of the Œsophagus.

Vollbracht presented a female patient, æt. 53, with an enormous pouch in the side of the œsophagus, caused by a stenosis at the cardiac end of the stomach. Nineteen years ago she was attacked with a severe febrile condition affecting the stomach and bowels, which lingered for some time. Nine months later she experienced difficulty in swallowing, which was found to be due to a narrowing at the cardiac end of the stomach. With the insertion of bougies and hydrotherapeutics she seemed to improve, and finally was passed off as cured.

In 1905 she was ill again, with increased difficulty in deglutition. The stenosis was found by measurement, 42 centimeters from the gums, and with difficulty a No. 16 bougie could be passed through the narrowing opening into the stomach. Above the stenosis the 16½ inches had a capacity of 450 cubic centimetres, or 16 ozs. In the stomach there was also an hourglass contraction, which increased the difficulty, but after a little manœuvring the sound could be got forward. By taking long inspirations and expirations, Valsalva's symptom was produced—viz., a cessation of the radial and carotid pulse while the intrathoracic pressure was increased. When manœuvring, air was pumped into the œsophagus with the glottis closed, which relieved the resistance of the cardia, when the contents of the œsophagus passed into the stomach with a rushing noise.

No real morbid condition could be assigned for the origin of this troublesome stenosis beyond a cardial spasm of the œsophagus producing the dilation above.

Glas said he preferred the œsophagoscope for such cases, as the details of the ecstasia could be observed and the extent of the dilatation exactly measured; the presence of tumours, ulceration, or other cicatricial tissue, as well as the interior walls of the dilatations are all brought into view. In addition to this, he applied the rays as a routine matter of confirmation.

Schwanz related a case of a purely nervous origin arising in the cardiac portion of the œsophagus, which produced a large spindle-shaped dilatation. Its first appearance dated as far back as 30 years, which was ushered in by severe dysphagia, vomiting and extreme inanition. The Röntgen rays revealed the psychic influence. In company she was unable to get anything into the stomach, but in private she could with great pain. The most notable feature in this case was when she was taken to the seaside, after long courses of treatment, she instantly recovered and could eat heartily at every meal.

HUNGARY.

Budapest, Oct. 28th, 1906.

At the recent meeting of the Nagyvarad Medical and Pharmaceutical Society, Dr. Adolf Erdös read a paper on

Urotropin and Helmitol.

The properties of urotropin as uric acid solvent and urinary antiseptic are almost solely due to small amounts of formalin, which are split up both in acid and alkaline solution. It is therefore invaluable in acute and chronic cystitis, pyelonephritis, pyelitis, and posterior urethritis, and typhoid infection of the

bladder, to prevent nephritis in scarlet fever. After the use of instruments and in phosphaturia. The urine of patients who have taken urotropin will become ammoniacal less readily if kept than normal urine.

A comparatively new compound is the methylene citric acid salt known as "Helmitol." It is said to be superior, since decomposition occurs less readily, and the acid radical itself is a derivative of formalin. According to Dr. Erdös, helmitol does not, however, possess any therapeutic advantages, inasmuch as cases that do not yield to urotropin are not much benefited by this derivative. It is also more expensive, as larger doses are required, and the acid radical occasionally shows toxic propensities such as gastro-intestinal disturbance and eczema. The bromine water and Toressen tests for formalin in the urine are equally marked after corresponding doses of the two drugs, and the urine after the use of helmitol does not inhibit the development of bacteria any longer than with urotropin. Since helmitol is twice as expensive as urotropin, the latter should be given in all cases.

SYPHILIS IN THE APES.

Dr. Lazar reported an account of the successful inoculation of a chimpanzee with syphilitic virus from human sources. He stated that he also succeeded in inoculating a second chimpanzee with virus obtained from the first. The resulting eruption took the form of a generalised papular syphilide, and was well shown in a number of photographs which he had taken. The animal died shortly after with acute miliary tuberculosis, and the diagnosis could be verified by microscopical examination of the papules. He claims that this investigation demonstrates conclusively that infection of the higher apes with syphilis is possible, and that this animal may serve as a test object, as it were, for the virus and perhaps permit of the production of a specific serum.

PURIFICATION OF WATER WITH COPPER SULPHATE.

The Director of the Water Works of the City of Budapest made the statement that the water as it will be supplied to the city after completion of filtration plant will be absolutely pure, and will not need the addition of copper sulphate to render it free from typhoid bacilli. He said that the Department of Public Health, in doing what it had toward the use of copper sulphate, was striving for the purification of the water now being served. He is a firm believer in filtrated water, but does not advocate sitting quietly by and letting the scourge of typhoid continue, while the filters are being completed. The experiments in the laboratory are for the benefit of Budapest's inhabitants, until they are served with pure filtered water. Most of the speakers agreed that the use of copper sulphate in far greater quantities than are recommended for purifying the water would be harmless to the general population.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

EDINBURGH UNIVERSITY GENERAL COUNCIL: PROPOSED AUTONOMY.—The business of the statutory half-yearly meeting of the General Council, held on the 26th inst., was of more than ordinary interest and importance. One of the disadvantages under which the Scottish universities lie is that none of them is completely autonomous. That is to say, that through the operations of successive university commissions, such a petty alteration as the inclusion of a fresh subject in a curriculum or the reduction of the number of lectures in a course can only be effected by a new ordinance. The ponderous procedure enjoined by the Act of 1889 involves the preparation by the university court of a draft ordinance, its submission to the General Council and Senatus for opinion, the promulgation of the ordinance to the other university courts, who may within two months lodge objections with the Privy Council, a report from the Universities Committee of the Privy Council, and the lying before Parliament for twelve weeks of session before Royal approval can be given. It is no wonder that such circumlocution leads to intolerable delay; a year may be spent in passing an unopposed ordinance, and four years have passed in the as yet unsuccessful attempt to get an unopposed one through. The crux of the question is whether each university is to be free to go its own way, or whether, as in the past, they must all toe the same line, neither advancing without the consent of her fellows. The arguments in favour of this uniformity are that the universities would start underselling each other, and that Edinburgh and Glasgow, being the more powerful, would outrun Aberdeen and St. Andrews if left to choose their own pace. It seems hardly necessary to do more than state such arguments in this bald manner to refute them. They only suggest the reflection that to offer them seriously involves the assumption that the community exists for the benefit of the universities, not the reverse. The Business Committee of the General Council, having received notice of the University Court's sympathy with the movement towards autonomy, have drawn up a report which was submitted to Friday's meeting. Their proposal is to create for each university a legislative council, to alter and make ordinances in all matters at present regulated by ordinance, and in regard to all other matters not already fixed by Act of Parliament. The Legislative Council for Edinburgh might (it is suggested) consist of fifty members, made up of the Chancellor and representatives appointed by the Court, General Council, Senatus, Lecturers and Assistants, Students' Representative Council, Crown, Town Council, other universities, Royal Colleges, Royal Society, Royal Infirmary, School Board, Merchant Company, Heriot Trust, and Chamber of Commerce. The scheme as above outlined was adopted as a basis for discussion with the proviso that the Council did not stand committed to its details. It is premature to express any opinion on the liklihood of such autonomy being attained in the immediate future, and no doubt in many points careful consideration and criticism will be required. But of the broad principle that the universities should be self-governing, no one who desires reforms has any doubt, and a legislative council like the above certainly appears to represent nearly all the interests concerned in university work, and would bring the University into close touch with most of the other educational authorities in the city.

COMPULSORY NOTIFICATION OF CONSUMPTION.—At the last meeting of the Glasgow Town Council a minute of the Public Health Committee advocating the compulsory notification of pulmonary phthisis was passed unanimously.

PHYSICAL CONDITION OF THE CHILDREN OF EDINBURGH POOR.—A volume has just been issued by the Edinburgh Charity Organization Society reporting on the results of the examination of 1,400 school children in one of the poorest districts of the old town. The report is of great interest on account of the exhaustive nature of the investigation, for not only was the physical condition of the children examined by medical experts, but their home surroundings were inquired into by named visitors. We can only briefly mention a few of the points raised in the volume, which is well worth the attention of all interested in social reform and the health of the community. One feature of the statistics is the large percentage of cases in which the mothers were wage-earners—282 out of 781 families—and this was found to be closely connected with drinking on the part of the father. Only 29 of these working mothers were from sober, respectable homes. A fifth of the houses visited were "ticketed" according to the city regulations, as containing less than 2,000 cubic feet, the allowance being 400 feet for each adult. Overcrowding, however, was as common in the larger, "unticketed" houses as in these; in one case the space worked out at 143 cubic feet per inhabitant. Rather less than 20 per cent. lived in one-roomed houses, and

rather over 50 per cent. in two-roomed houses. Another 20 per cent. lived in three-roomed houses, and the rest in four and five-roomed houses. Turning to the details of more purely medical interest, 45 per cent. of boys, and 42 per cent. of girls, were of excellent or good mental capacity, and about 18 per cent. of boys and 20 per cent. of girls were classed as dull or defective As to general health appearance, 9.5 per cent. were bad, 45.7 were medium, and 44.8 were good. The nutrition was poor, nearly one-third being classed as thin, the largest number of these being between the ages of 6 and 9. As regards alertness in answering questions, 20 per cent. were given as bad, these being almost entirely drawn from children classed as poor in general health and nutrition. At all ages the weights of boys and girls compare unfavourably with the Anthropometric Committee's standard. The deficiency was least among the young children (about 2½ lbs. at 5 years) and progressed steadily with age, at 13 being about 11 lbs. The stature was also defective. Of 1,330 children whose eyes were examined, 10.44 per cent. suffered from some affection of the ocular apparatus; 12.87 per cent. were working under eye conditions which formed a barrier to progress; 42.49 per cent. suffered from nose or throat affection. Functional heart disease occurred in 38 cases. Nearly 70 per cent. had unhealthy skins. At all ages the chest capacity of children living in houses of one room was least, though the difference from the average was not great.

LETTERS TO THE EDITOR.

"DIRECT REPRESENTATION" ON THE GENERAL MEDICAL COUNCIL.

To the Editor of The Medical Press and Circular.

Sir,—No one who has adequate knowledge of the facts will dispute the statement in the last sentence of Mr. Rutherford Morison's letter published in your issue of the 24th inst. It is certain that, "without a new Medical Act passed on the lines adopted by the British Medical Association, the chief evils from which the profession now undoubtedly suffers cannot be satisfactorily dealt with." It is, however, equally certain that there hardly exists the remotest chance that the present Government will introduce or support such an Act, and it is more certain that no private member, unsupported by the Government, can carry such a measure through Parliament.

This opinion, supported by argument, I stated in the *British Medical Journal* a year or so ago, and I have repeatedly discussed the question in your columns. Before new legislation becomes possible, it will be necessary to prove that it is demanded more for the protection of the public than the advantage of the profession. This, as I have suggested, can be done in the most complete and convincing fashion through the medium of a Royal Commission, and in no other way. The infamy of quackery, including the quack medicine trade, could be there clearly and fully demonstrated. A hideous story of cynical villainy would be unfolded which could not fail to touch the consciences of the intelligent classes and of their representatives in Parliament. In the case of the lawyers it has been shown that practice by fraudulent pretenders can be easily prevented; and there could be no difficulty in constructing equally effectual legislation for the doctors. The greater part of the trade in quack medicines could be brought within the scope of ordinary criminal law. Most quack medicine vendors could be made liable to prosecution for obtaining money under false pretences, and could be placed under the surveillance of the police. It must be borne in mind that no help in this movement will be given by the lay Press. From the *Times* downwards they are all taking a share of the enormous sum—certainly more than a million sterling—which is being spent annually in advertisements by quacks. Exposure of the facts before a Royal Commission might bring shame to some of the wealthier newspaper proprietors, and we might hope that one or two of the noble lords who own leading papers, and who are now augmenting their incomes by participation in this nefarious traffic, would turn away and throw in their influence on the side of reform. They would, at any rate, no longer have the excuse of ignorance to justify their conduct.

I am, Sir, yours truly,

Henry Sewill.

Cavendish Square, October 25th, 1906.

To the Editor of The Medical Press and Circular

Ladies and Gentlemen,—In placing my services at the disposal of the profession in the ensuing election for Direct Representatives on the General Medical Council, I may be allowed to say that, in order to show that my efforts in the past have not been confined to a narrow groove, I have been for many years a member of the British Medical Association, and since the Cheltenham meeting a member of its Central Ethical Committee and its representative on the Contract Practice Sub-Committee in 1905-6, that I have attended all the representative meetings of the Association on behalf of the North Manchester Division; that I am a member of the Council of the Lancashire and Cheshire Branch; a vice and ex-President of the Incorporated Medical Practitioners' Association and have been a member of the Council of the Medical Guild practically since its foundation some 14 years ago and took an active part in its initiation. All this has given me considerable insight and experience as to the difficulties and trials as well as shortcomings of everyday practice which might prove useful in the General Council of Education and Registration in London.

I have recently expressed my views in the "British Medical" and other journals as to the necessity of lectures being given to senior students on ethics to supply the deficiency caused by abolishing the apprenticeship system, and of raising the standard of preliminary education, both in arts and science, before registration, which I need not repeat now.

I am also in favour of stringent action on the part of the Council in any proved cases of touting for vaccination on the part of the Poor-law Medical Officers or their agents, even in those employed by the guardians, and I would go so far as to consider whether proved cases of gross underselling should not be considered "infamous conduct in a professional respect," not only as an injustice to their fellow-practitioners but as lowering the dignity of the profession in the eyes of the public.

The craze now for registration that midwives have secured is certain to be attempted not only for nurses but spectacle-makers, herbalists, etc., and will require careful watching during the next five years, and the General Council will require keeping on the alert not only for the protection of the public, but if it were possible that of the profession as well, inasmuch as the President has stated that the Council's resources are not yet exhausted. Abolishing unqualified assistants not only benefited the public but the profession.

It has always been my endeavour, in season and out of season, to secure as far as possible the union and the interests of the profession, and especially by promoting new as well as old combinations of various kinds.

My personal experience of Provident Dispensaries, and another large provident association, when on the staff of which I fought for th honour and dignity of the profession in the face of strong opponents, and for many years since leaving them, for a wage limit, is well known in my immediate neighbourhood. All this practical experience, in addition to that gained as a general practitioner for upwards of a quarter of a century, would surely be of use in a Council composed mostly of professors and consultants who know nothing

of these matters personally, and would be of assistance in cross-examination of delinquents when brought before it.

If it is possible in a new Medical Act to protect the public from the barefaced assumption of medical titles, especially by companies, and from other means of deceiving it, I need not say that it will have my hearty support.

The experience gained during the three years I have sat on the Central Ethical Committee of the British Medical Association, not one meeting of which have I been absent from, ought to be of some service to me if elected to the General Medical Council.

The reckless distribution of medical services without any regard to wage limit to the injury of respectable qualified practitioners should surely be adjudged "infamous conduct in a professional respect" as in any other.

Believe me, Ladies and Gentlemen,
Yours faithfully,
G. H. BROADBENT,
M.R.C.S.Eng., L.R.C.P.I., L.M.

8, Ardwick Green,
Manchester,
October, 1906.

LAW FOR LAWYERS AND LAW FOR DOCTORS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In the *Times* of Monday, October 22nd, appears the report of another case illustrating the complete protection afforded to the legal profession and the public against the practice of unqualified men as solicitors. A debt-collector had used words to the effect that unless the money claimed were paid to his client, he would be obliged "to take the case to the High Court." He had adopted no title and used no expression beyond the one cited which could be distorted into an attempt to palm himelf off as a solicitor Yet the magistrate held that the words could properly be used only by a qualified man, and inflicted a fine of £10 and costs, with the alternative of imprisonment. When it is considered that the practice of medicine in its various branches by quacks inflicts upon the public vastly greater injury than could be brought about by any amount of unqualified practice in the law, it is impossible to believe that if the facts were fully exposed, legislation would not be speedily attempted to put an end to some of the evils due to the present weakness of the Medical Acts. When will the profession wake up to a sense of its duty in this matter to itself and to the public? When will it take steps to prove its case and demand the legislation so urgently called for?

I am, Sir, yours truly,
AN AWAKENED "G.P."

October 23rd, 1906.

M.D., U.S.A.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In your last issue you commented upon the case of the Brighton man who sold powders for various diseases under the name of "Dr. Hawkins, M.D., U.S.A." You ask why the General Medical Council should not be empowered to prosecute in such cases, and echo answers "Why?" If a man carries on unqualified practice in the United Kingdom under a bogus or an unrecognised medical qualification, he is clearly open to prosecution. Now only last week a man giving the name "Dr. Riley, of Hanover Square, London, and Datchett," appeared at an inquest on the body of a woman whom he had prayed over as a Christian Scientist at the rate of a guinea per week. He said, in defence, that he had held the degree of the University of Missouri, but was struck off the roll in 1897, when he joined the Scientists. It appears he still appends the letters M.D. to his name. Perhaps the secretary of the Medical Defence Union, Dr. Bateman, will kindly inform us as to the exact legal position in this case. It would be well if the Union also gave us full particulars as to the nature of the business carried on at Hanover Square. What is the exact address, and is it connected with electrical or any other form of special treatment.

I am, Sir, yours truly,
AN EXTINGUISHED PRACTITIONER.

West Kensington, October 30th, 1906.

THE SUPPRESSION OF QUACKERY.—DENTAL SURGEONS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—You are placing dental surgeons under an obligation by the consideration you are giving to their speciality in your efforts to promote medical law reform. In 1858 the Royal College of Surgeons obtained, through the new Medical Act, power to institute a diploma in dental surgery. It was, however, not until 1878 that dentistry received full recognition, and was placed under the control of the Medical Council. The Dentists' Act of 1878 was passed through Parliament without amendment. It was proved that the practice of dentistry could not be properly pursued save by educated professional men; it was sought to create a body of qualified practitioners equal to the demand, and to enable the public "to distinguish between qualified and unqualified practitioners." By giving dentistry a status as a profession the Act has attracted a large number of highly qualified men into the speciality. The Act has, like the Medical Acts, completely failed to afford these men any protection in return for the sacrifice called for in obtaining the State qualification; and it has failed equally in its object of protecting the public. There are more quack dentists now than ever. Some practice under the cloak of sham American "institutions"; others under the mask of limited liability companies. Quack dentists vary in badness, but many of them belong to the army of fraudulent pretenders denounced by the *Times* as "the most finished of impostors parasitic upon modern civilisation." Their victims are mostly simple and foolish women; the bait, artificial teeth of marvellous qualities, or teeth at a price which would not pay even if the job could be reduced to an operation as simple as the measuring for a pair of boots. The sham Americans catch the wealthier, the cheap tooth-purveyors take in the less wealthy classes. Both species of quack rob their victims, and misuse them. They both neglect the treatment of remaining diseased teeth and stumps, and leave the mouth in a septic state extremely prejudicial to the general health, as well as a frequent cause of serious local disease Not a single patient applying to the cheap dentist ever obtains a set of teeth at the price advertised; many times the price is mostly extorted for ill-made work, and many weak women of the kind easily recognised by a clever quack are virtually blackmailed. The quack's safety lies in the fact that no sensitive woman will go into the witness box to expose her folly. Any number of such cases will be brought forward if your project of a Royal Commission be realised.

I am, Sir, yours truly,
M.R.C.S., L.D.S.

DOCTORS' INCOMES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It is not easy to say whether any good will come from the "remarkable contribution" offered in the columns of the *Daily Telegraph* "to a controversy which has excited the widest interest at home and abroad."

The views expressed in the article in the *Daily Telegraph* (October 22nd) would lead one to the conclusion that the prospects of the general practitioner are not likely to improve. It would seem that things have changed so much of late years in the practice of medicine that hospitals have become a necessity, and that they are no longer limited to the class they were originally intended to benefit. The *Daily Telegraph* makes no allusion to the great system of rate-supported institutions, such as fever hospitals, infirmaries, asylums, etc., which carry on the chief part of the work once done by hospitals. Much the same change has come about in the treatment of the sick as in that

of education, and the influence of charitable sentiment does not enter, as it used to do, into the financial question of ways and means. No reference is made by the *Daily Telegraph* to this question, or the financial difficulties in which most hospitals find themselves. Some day, perhaps, there will be a change in the methods of legal procedure in this country, and some provision be made for the gratuitous aid required by the poor when in legal difficulties. The law certainly receives very far greater help from the State than medicine does, and it would have been well if the *Daily Telegraph* had pointed out clearly that hospitals will have to be supported in a very different manner than they are now if they are to carry on the work expected of them.

As to the general practitioner, the *Daily Telegraph's* remarks are generous and just; but no hope is held out to him that his "bitter cry" will be heard with pity and some form of consolation by the great class to which the work of his life is devoted.

It would have been well if the *Daily Telegraph* had clearly distinguished between the work of hospitals and the work of the general practitioner; how impossible it is for hospitals to meet the necessity for medical care, and help in the common family life of all classes; and how the general practitioner is as necessary as the hospital in preserving the health and well-being of the people.

I am, Sir, yours truly,

Cantabrigiensis.

OBITUARY.

EDWARD DRUMMOND, M.D.Edin., D.P.H.

We regret to announce the death of Dr. Edward Drummond, a well-known writer on medical subjects, who has just died at St. Annes-on-Sea. Educated at Edinburgh University, he began private practice at Oldham, where he obtained several public appointments, but in 1876, owing to ill-health, he took to travelling. He was later appointed physician to the British Embassy and Scots College in Rome, and while there made special contributions to the study of malaria, and also wrote a confidential report for the late Queen Victoria on vivisection in Italy. Following his return to England Dr. Drummond was a keen student of bacteriology, and made several valuable contributions to medical literature.

WILLIAM SEDGWICK, M.R.C.S., L.S.A.

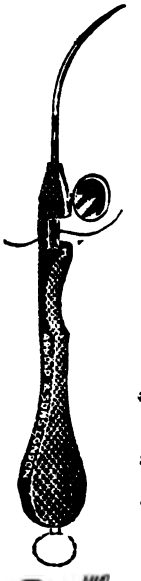
We record with sorrow the death of Mr. William Sedgwick, which occurred at Acton on October 20th. He had the interesting experience during his student days of acting as surgical dresser to Liston at University College Hospital, when the first operation in London was performed under an anæsthetic. After some voyages to India and China in charge of troops, Mr. Sedgwick settled in Marylebone as a general practitioner, but he also devoted a good deal of attention to the study of heredity, and published articles upon the subject. During the great cholera epidemic of 1854, Mr. Sedgwick devoted much attention to the chemical changes incidental to the disease, and made them, in 1889, the subject of his presidential address to the Harveian Society. He was for 13 years surgeon to the Marylebone Provident Dispensary and to St. Saviour's Hospital for Women and Children, Upper Holloway, and for upwards of 20 years honorary medical officer to St. Cyprian's Orphanage, Marylebone. He only retired from practice about two years ago.

WILLIAM BODKIN, M.D.R.U.I.

We regret to announce the death of Dr. William Bodkin, at the age of 63 years. For upwards of 40 years deceased was in practice at Chelmsford, where he was widely known, both in a public and in a professional capacity. His medical education was conducted at Queen's College, Belfast, whence he took the "M.D." degree in the Royal University of Ireland in 1867. He leaves a son, who recently qualified for the medical profession.

IMPROVEMENTS IN SURGICAL APPLIANCES.

NEW NEEDLE-HOLDER FOR POCKET-CASE.



Mr. Leslie Thain, M.R.C.S., Medical Officer to the Dore Union Workhouse, claims for this instrument that it will hold the usual bayonet needles of a pocket-case, and possesses the following essentials:—

Perfect grip of the needle by means of screw, tube, and rest-recess; funnel eye-finder—with it a needle can be threaded in the dark. It is roughened everywhere, and can be held anywhere, even with the forefinger nearly on the needle point.

By moving screw to the other end, it goes in a pocket-case, and is far more necessary than the combined Bellocq's and catheter. The method of use is: Move the screw to the needle channel. Hold the holder upright between left thumb and three fingers, back towards you. Drop needle into the tube till the eye end falls into the rest, and then, with left forefinger, press the concavity of the needle. The eye now corresponds to the eye-finder, and the needle can at once be threaded or after the next stop; now screw tight. Messrs. Arnold and Sons, London, are the makers.

IMPROVED VACCINATOR.

The same manufacturers have also made, at the suggestion of Mr. A. A. Mackeith, M.B., of Southampton, a vaccinator which he thinks embodies some slight improvements on those at present in use.

It combines in one instrument a lancet and a scarifier. The ends are kept clean by screw-on covers of distinctive sizes, so the instrument can be easily carried in the pocket or vaccinating case. The body or centre is square, which prevents the instrument rolling about, and is of such a size that the ends are prevented from touching the surface on which it is placed. The scarifier being bent at a considerable angle enables one to use the back of it to rub in the lymph. There is a small hole in each blade intended for use when breaking off the ends of the vaccine tube.

"SALODENT."

For Cleansing the Teeth and Mouth.

Salodent has been in use for many years, and has established its claims as a fragrant antiseptic for the mouth and teeth. We find that it contains aromatic antiseptics, such as salol, eugenol, pinol, &c., so combined in it that the whole cavity of the mouth, as well as the interstices of the teeth may be scientifically cleansed. "Salodent" may be used in two ways: as a mouth-wash and as a tooth-cleanser. From personal experience we can testify to the excellence of this preparation, which is well up to the standard of modern scientific preparations for the toilet of the mouth.

MEDICAL NEWS IN BRIEF.

A Partnership Dispute.

SOME singular facts about a doctor's partnership came to light in the Marylebone County Court on the 25th inst. Dr. H. L. Snow, late senior surgeon at the Brompton Cancer Hospital, sued Dr. S. W. Wilson, of Brondesbury, late Registrar of the Irish Medical Council, for £94 odd in respect of breach of a partnership agreement, etc.

According to Dr. Snow, premises situated in High Road, Kilburn, were opened by him in September of last year as a dispensary for women. In January of the following year he advertised and defendant entered into partnership. Both parties were to share the expenses of the undertaking. In July, Dr. Wilson met his partner, and told him that unless he could show that he had paid the last quarter's rent of the premises he should break the connection. Dr. Snow informed him that the account for the rent had not been presented, but, in spite of this, defendant failed to perform his duties that day, and on the following day, when plaintiff went to the surgery, he found that defendant had carried off bottles, instruments, drugs, and pills, so that it was impossible to attend to any patients had they applied for treatment.

Cross-examined, plaintiff admitted that he had advertised the business at price of fixtures, "on account of sudden illness of vendor." The last clause was put in because he had had three attacks of influenza, and was not meant to deceive, although he was able to attend to his duties when the advertisement was inserted. With regard to phrase, "no competition," plaintiff said he was not aware that there were fifty doctors within a radius of half a mile of the place.

"Were you not distributing advertising matter in connection with this dispensary from door to door shortly before you entered into negotiation with defendant?"—"Yes."

"Don't you know that the General Medical Council have struck doctors off the Register for advertising?"—"I do not."

"Did you not receive a letter from the Medical Defence Union, in which the writer said, 'I am directed to call your attention to what would appear to be some misuse of your name by some person impersonating you'?"—"Yes."

"And did you write back to say that some ill-advised person had been personating you, and that you would inquire into it and see that it was stopped?"—"Yes."

"So you were going to inquire into a distribution of circulars that you were paying the Church Army to distribute, and you told Dr. Bateman that somebody was impersonating you?"—"I thought the letter was offensive."

"Did you tell your partner of this advertising?"—"No, because it was stopped before he started with me."

For the defence it was submitted that plaintiff had confessed to using the money which defendant paid him for rent for household purposes, and that Dr. Wilson was so alarmed by the evident embarrassment in which his partner was that he felt justified in breaking the partnership.

Sir William Selfe said that he considered there was ample reason for the defendant's claim for a dissolution of partnership. Plaintiff's reply to the letter from the Medical Defence Union was disingenuous. The plaintiff would be indemnified for half the rent he might have to pay for the premises he had taken after he had proved that the money had been paid, but no order for costs would be made.

Royal Commission on Vivesection.

IN the House of Commons on the 25th inst., in answer to Mr. O'Grady (Leeds, E.), Mr. Gladstone said: I have received and considered a certain number of representations, but I do not propose to enlarge the Commmission, which is, in my opinion, fairly constituted as regards all parties interested. It is for the Commission to decide whether their proceedings should be public, and they have, I see, informed the Press this morning that they have decided to sit in private, but to supply copies of the evidence from time to time to certain representative bodies interested in the inquiry.—Mr. O'Grady asked whether it was not the fact that the majority of the Commissioners believed in vivisection.—Mr. Gladstone replied that out of ten Commissioners, four, including two distinguished medical men, were suggested to him by the Anti-Vivisection Society.—Mr. Lupton asked whether it was not the case that there were three vivisectionists on the Commission and no expert anti-vivisectionist at all. (Laughter.)—Mr. Gladstone replied that he did not know what his hon. friend meant by "expert anti-vivisectionist," but in the constitution of the Commission great care was taken to secure that all sides should be represented.

An Uncertificated Midwife.

ANN TROTT, of Totterdown, Bristol, was recently convicted under the Midwives Act, 1902, for using the name of midwife without being certificated, contrary to the provisions of the Act. Prior to the Act the woman had acted as a midwife, and should have registered herself as such, but she had not done so, and still kept up her plate on the house in Bath Road. The defendant said she had done this work for thirty years. P.C. Ryall said the defendant had been cautioned by the coroner and deputy-coroner and himself that she should take her plate down if she had no certificate. The defendant said her husband was blind and a cripple, and she had to maintain him. The plate was now taken down. The magistrates pointed out that the defendant must not go on practising unless she was registered, and she would be fined only 5s. and costs, as it was a first case.

Cost of an Epidemic.

IN 1905 Basingstoke was visited by an epidemic of typhoid, caused, it was believed, by the contamination of the water supplied from the corporation waterworks. That outbreak will cost the ratepayers upwards of £5,000 before it is done with. The hospital expenses and incidentals came to £2,500, for which the Local Government Board sanctioned a loan, repayable in five years, and this has just been taken up at £3 17s. 6d. per cent. There were no less than fifty actions brought against the corporation for compensation, and these were compromised at a cost of £1,670 15s., to which has to be added £600 to defend the actions up to the time of settlement. The Council have now decided to distribute £425 amongst 68 sufferers who did not bring actions. To meet these payments a supplemental rate of 1s. in the £ has been made. The repayment of the loan mentioned above will mean an addition of about 3d. to the rates each year.

Metropolitan Street Ambulance Association.

THE Metropolitan Street Ambulance Association, which was founded in 1904 to institute a working system of relief in cases of street accidents in London, has issued a manifesto to explain how it is that so little progress has been made. It appears that on August 3rd the Home Secretary said that he had the matter under his consideration, and the matter has thus

passed out of the realm of private or municipal enterprise and assumed a national character. Till, therefore, the Home Secretary is ready with a scheme, everybody else must mark time. The difficulties surrounding the question are great, not the least being the financial. But if the taxpayer is to come to the assistance of the scheme no doubt progress will rapidly be made.

Royal Commission on the Treatment of Lunatics.

The Royal Commission on the Care and Control of of the Feeble-minded have been entrusted with a new and important task. By an extension of their terms of reference, the additional duty has been imposed upon them of inquiring into the constitution, jurisdiction, and working of the Commission in Lunacy, and of other Lunacy authorities in England and Wales.

They will also investigate the expediency of amending the present system by the adoption of some other method of supervising the care of lunatics and mentally defective persons, and will report as to any amendments in the law as it now exists.

The Malthusian League.

A Conversazione will be held at South Place Institute, South Place, Finsbury, on Thursday, November 8th, at 7.30 p.m., when a short address on "The Rise and Progress of the Neo-Malthusian Movement," will be delivered by the President, C. R. Drysdale, M.D., M.R.C.P., F.R.C.S., followed by a discussion. Tea and coffee will be served, and instrumental music by members of Prince's Red Band will form part of the entertainment.

St. Vincent's Hospital, Dublin, Annual Dinner.

The annual dinner of the medical staff and past students of this institution was held on Tuesday, October 23rd, at the Shelbourne Hotel. The chair was occupied by Mr. Tobin, Surgeon to the Hospital, and a large number of distinguished guests were present. After dinner the toasts proposed included "The King," "St. Vincent's Hospital," proposed by the Chairman; "Our Guests," proposed by Mr. McArdle and responded to by the Archbishop of Tuam, Sir Christopher Nixon, Surgeon-General O'Farrell; "The Past Students," proposed by Dr. Cox; and "The Chairman."

PASS LIST.

Royal College of Physicians of London.

At the ordinary quarterly comitia of the College, held on Thursday last, the following gentlemen, having undergone the necessary examinations, were admitted to the membership:—C. H. Benham, M.D. Lond., L.R.C.P., Univ. Coll. Hosp.; W. Haig Brodie, M.D.Edin., F.R.C.S., St. Mary's and St. Barth.; P. Kevin Byrne, M.D.Lond., L.R.C.P., Univ. Coll.; E. Nicholson Cunliffe, M.D.Vict., Owens Coll.; H. Devine, M.B.Lond., L.R.C.P., King's Coll. and Bristol; J. McCrae, M.B., Toronto, L.R.C.P.; C. Oldfield, M.D.Lond., L.R.C.P., Leeds; A. Corsar Sturrock, M.D.Edin.

The Conjoint Board for England.

The following candidates having passed the Final Examination (in Medicine, Surgery, and Midwifery) of the Examining Board in England, the Licence of the Royal College of Physicians was conferred upon them on Thursday last. The names are arranged alphabetically:—E. H. Adams, E. Alban, E. Balthasar, A. L. Baly, M.A. Cantab; G. B. Bartlett, B.A. Cantab., H. G. Bennett; A. W. Berry; M. Birks, M.B., S.B., Adelaide Univ.; P. Black, B.A. Cantab.; H. O. Blanford; L. H. Bowkett; J. E. M. Boyd; G. G. Butler, B.A. Cantab.; W. E. Carswell, M.B., Ch.B., New Zealand; C. Cassidy, B.A. Cantab; J. B. Close; A. G. Cole; H. G. Cole; I. R. Cook; B.S. Lond.; J. Couper; S. B. Couper, B.A. Cantab.; P. P. Daser, M.D., Innsbruck Univ.; H. R. Davies; G. H. Dive; F. C. Doble; L. Doudney; S. F. Dudley; A. G. Dunn, M.B., B.S.,Durh. Univ.; L. Edwards; R. R. Elworthy; D. Embleton, B.A. Cantab.,; C. H. J. Fagan, B.A. Cantab; J. S. Farnfield, L.D.S.; C. H. Fernie;. P. Fiaschi, M.D. Columbia Univ.; R. D. Forbes, M.D., McGill Univ.; G. Foord, M.B., Toronto Univ.; W. Gabe; R. F. Gerrard; C. W. Gittens; G. E. Green; S. W. Grimwade; J. R. Gunne, M.D., B.Ch., Manitoba Univ.; E. H. R. Harries; T. S. Harrison; T. S. Hele, B.A. Cantab, B.Sc. Lond.; D. W. Hume; R. W. Ironside, B.A. Cantab.; T. j. Jenkins; D. M. Keith, Mich. Univ.; T. L. Kenion; W. R. Kilgour; W. H. King; C. Lebon, M.D., Strasburg Univ.; W. H. Lee, B.A. Oxon.; R. B. Low; J. A. McCollum, M.B., Toronto Univ.; O. R. McEwen; W. E. McLellan, M.B., Toronto Univ.; P. D. F. Magowan; E. S. Marshall; J. D. Marshall, M.B., Ch.B., Victoria Univ.; D. M. Masina, Bombay; E. W. Matthews; H. Maxwell; C. A. Mayer; F. E. W. Meadows; O. Le Fevre Milburn; S. W. Milner; H. V. Mitchell; W. S. Mitchell; E. Morgan; R. J. Mould, B.A. Cantab.; L. D. Neave; F. M. Neild; R. B. Nicholson; H. J. Nightingale; T. Norman; H. W. Ogle-Skan; M. W. B. Oliver, B.A. Cantab; G. G. Packe, B.A. Cantab; G. S. Parkinson; E. H. A. Pask; G. D. Perry; G. R. Phillips; A. J. S. Pinchin; A. M. Pollard; E. S. Prior; A. E. Pryse; R. M. Rendall; A. T. Rivers; P. M. Roberts, M.B., B.S. Lond; R. C. Roberts, B.Sc. Lond; I. J. Roche; T. R. St. Johnston, L.S.A.; C. N. Slaney; H. A. Smith, B.A. Cantab.; F. M. W. South; H. M. Staley; P. K. Steele, M.B., Ch.B. Vict.; A. C. H. Suhr, B.A. Cantab; D. W. Tacey, M.B. Cantab,; D. C. Taylor; O. Teichmann, B.A. Cantab.; H. E. H. Tracy, L.D.S.; C. Trapnell, E. A. Cantab.; W. H. Trethowan; C. Tylor, B.A. Cantab.; I. Valerio, Costa Rica; J. P. Walker, M.P.S., Leeds Univ.,; S. L. Walker, B.A. Cantab; C. G. Welch; C. E. Whitehead, B.A. Cantab; R. H. Williams; W. S. Williamson; H. D. H. Willis-bund; J. G. Willmore, McGill Univ.; J. L. Wood, B.A. Cantab; E. M. Woodman; H. N. Wright; A. B. Zorab; and C. E. Zundel.

Royal College of Physicians of Ireland.

At the stated annual meeting of the Royal College of Physicians of Ireland, the following officers were elected for the coming year:—

President, Dr. Joseph M. Redmond; Vice-President, Dr. Conolly Norman; Censors, Dr. Conolly Norman, Dr. Murphy, Dr. H. Jellett, and Dr. R. T. Smith. Additional Examiners to take the place of an absent Censor or Examiner—Medicine, Dr. J. A. Matson; Medical Jurisprudence and Hygiene, Dr. A. N. Montgomery; Midwifery, Dr. Glenn. Examiners for the Licence to practice Midwifery—Dr. Horne and Dr. Wilson. Examiners for the Membership—Dr. J. F. O'Carroll and Dr. Travers Smith. Clinical Medicine—Dr. Wallace Beatty and Dr. John Murphy. Practice of Medicine—Pathology, Dr. H. C. Earl and Dr. A. C. O'Sullivan. Supplemental Examiners under the Conjoint Examination Scheme—Biology, Dr. T. P. C. Kirkpatrick; Chemistry, Professor E. Lapper and Dr. N. Falkiner; Physics, Dr. G. J. Peacocke and Dr. W. A. Winter; Pharmacy, Materia Medica, and Therapeutics, Dr. H. C. Drury and Dr. M. Dempsey; Physiology, Dr. H. C. Earl; Pathology, Dr. E. J. M'Weeney; Medicine, Dr. A. R. Parsons and Dr. W. J. Thompson; Hygiene and Forensic Medicine, Dr. W. R. Dawson. Examiners for the Conjoint Diploma in Public Health—Chemistry, Professor E. Lapper; Hygiene, Dr. H. T. Bewley; Meteorology, Dr. W. A. Winter. Extern. Examiners for the Conjoint Preliminary Examination—Science, Mr. R. A. P. Rogers, F.T.C.D.; Languages, Mr. E. H. Alton, F.T.C.D.; Irish, the Rev. Professor Murphy, M.A. Representative on the General Medical Council, Sir John W. Moore. Representatives on the Committee of Management, Dr. Walter G. Smith, Sir John W. Moore, and Dr. Craig; Treasurer, Dr. H. T. Bewley; Registrar, Dr. James Craig; Librarian, Mr. R. G. Phelps; Architect, Mr. A. E. Murray, C.E.; Law Agents, Messrs. Stephen Gordon and Sons; Agent to manage the Trust Estate, Mr. C. U. Townshend, J.P.

During the proceedings the President admitted Dr. John F. W. Tatham, F.R.C.P.Lond., to the Honorary Fellowship.

In the evening the annual dinner of the President and Fellows took place in the College Hall.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS. ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT PATHOLOGICAL LITERATURE.

Serum Treatment of Cerebro-Spiral Meningitis.—Flexne (*British Medical Journal*, October 20th, 1905) publishes an account of experiments in the serum treatment of cerebro-spinal meningitis. (1) He produced by inoculation of rabbits an anti-serum with marked protective power for guinea-pigs. The serum was injected in guinea-pigs (i.) 24 hours before the cocci were injected, (ii.) simultaneously with the injection of cocci, (iii.) some hours after the injection of cocci. The animals treated survived, whereas the control animals all died. (2) He produced by inoculation of large monkeys (*macacus nemestrinus*) an anti-serum with effect on smaller monkeys (*macacus rhesus*). Five monkeys were treated. The first received the serum (1 c.cm.) and the suspension of cocci (a lethal dose) simultaneously into the spinal canal; it remained well. Lumbar punctures showed a moderate reaction and rapid disappearance of the cocci, partly by phagocytosis, but also by lysis. The second monkey was given the serum two hours after the cocci; it became very sick, but recovered. The exudation in this animal was much more marked, and the cocci were only in part taken up by the leucocytes. The third monkey was injected with the serum five hours after the cocci were given. The disease, which had already shown itself, was arrested, and next day the animal was well. The fourth monkey was treated by subcutaneous injection two hours after the introduction of the cocci; it also recovered. The result in the case of the fifth monkey was a surprise. The injection of the serum had no effect on the progress of the disease, and the animal died. Control animals in every case died. The result of the experiments as a whole is very encouraging. It is shown that an anti-serum can be produced possessed of marked preventive and curative properties. It remains to be shown that some such serum can be applied to man, and that the introduction of an alien serum is not harmful.

R.

The Viability of the Typhoid Bacillus.—Wheeler (*Journal of Medical Research*, September, 1906) publishes a report of extensive experiments bearing on the viability of the typhoid bacillus. He concludes:—(1) The typhoid bacillus reproduces itself for several days in sterile water, particularly if there be any organic impurities present. (2) Diffused daylight acting through a thin layer of water is hostile to the growth of the organism. (3) The optimum temperature for the multiplication of typhoid bacilli in sterile water is 20-22° C. (4) Not all saprophytes are antagonistic to the typhoid bacillus. One, *B. carrotoverus*, manifests symbiotic relations with it. (5) Freezing reduces the number of typhoid bacilli in water, and typhoid bacilli do not live long in ice. The last of these conclusions is at variance with recent opinion, and as the point is one of much importance in cold countries, it will demand further study.

R.

The Organism of Hydrophobia.—Williams and Lowden (*Journal of Infectious Diseases*, May, 1906) review and summarise our knowledge regarding the so-called "Negri bodies" observed in hydrophobia. They have themselves worked by the smear method, and have demonstrated that examination of smears is quite as trustworthy as examination of sections, and is much more simple. According to them the Negri bodies are found before the beginning of visible symptoms, and are also found in fixed virus. In both these points the authors have made an advance on previous knowledge, the apparent absence of the bodies in the fixed virus having hitherto been considered an argument against regarding the bodies as causal in hydrophobia. Very small bodies have been observed which are probably capable of passing through the coarser Berkefeld filters. The authors believe that the bodies are protozoa with a definite morphological cycle, certain forms always predominating at certain stages of the disease. They further regard them as the specific cause of hydrophobia. Detailed instructions are given as to the methods of staining by Giemsa's solution and by eosin and methylene blue, both methods being simple and satisfactory.

R.

The Organism of Whooping-Cough.—Bordet and Gengou (*Annales de l'Institut Pasteur*, September 25th, 1906) describe an organism discovered by them in cases of whooping-cough. It was first described in 1900 as present in large quantities in the sputum, but at that time attempts at culture failed. It is an extremely small, ovoid bacillus, with a tendency to show polar staining. It fails to grow on ordinary media which have been subjected to sterilisation in the autoclave, but it grows readily in liquid media containing blood or blood serum. It is found in large quantities in the sputum in the initial stages of the disease. Moreover, the serum of patients suffering from or recently recovered from whooping-cough has a marked agglutinating action, whereas the serum of other subjects shows no such activity. The authors are now engaged in experiments regarding serotherapy and active immunisation.

R.

Spirochætes in Yaws and Granuloma Pudendi.—MacHennan (*British Medical Journal*, October 20th, 1906) notes that he has discovered spirochætes in smears from a papilloma in recurrent yaws. The method of staining was by Giemsa's solution and gentian violet, and the spirochætes observed possessed the same properties as the *spirochæte pallida*, but that the staining was fainter. Loops in the course of the filament were observed, as in the case of the *spirochæte pallida*. In the *granuloma pudendi*, on the other hand, no organism was seen at all resembling the *spirochæte pallida*. A few organisms resembling the *spirochæte refringens* were seen, and a number of highly refractive, very long spirochætes, with fine and close waving.

R.

The Typhoid Bacillus in the Lungs.—Robinson (*Bulletin of the Ayer Clinical Laboratory*, June, 1906) reports some instructive cases in which typhoid or similar bacilli were held responsible for lesions of the lung. In the first case the patient, at the end of the fourth week of a typical attack of typhoid fever, suddenly showed signs of infarction of the lung and died eight days later. At autopsy the main artery to the lower lobe of the right lung was found thrombosed, and the lobe was converted into an abscess cavity. There was also a general broncho-pneumonia. The typhoid bacillus was separated from the abscess and from other parts of the lung. This is the only case of six of broncho-pneumonia complicating typhoid fever examined at the Pennsylvania Hospital in which the typhoid bacillus was found in the lungs. In the second case the patient died on the eighth day of an illness presenting typical physical signs of pneumonia. He had bloody expectoration, and a low leucocyte count. At autopsy there was found a hæmorrhagic type of pneumonia, and from the lung tissue was obtained a pure culture of the B. paratyphoid bacillus. The third case was that of a man who developed pneumonia in the fourth week of an attack of typhoid fever. From his sputum and from his blood the typhoid bacillus was separated. Robinson gives copious references to

similar cases in the literature, and seems justified in concluding (1) that the typhoid bacillus not infrequently invades the lungs during typhoid fever; (2) it may there give rise to abscess and broncho-pneumonia; (3) lobar pneumonia, occurring in typhoid fever, is usually due to the pneumococcus, but it may be caused by the typhoid and the paratyphoid bacillus, and is then hæmorrhagic in type; (4) the typhoid bacillus may be found in the sputum of typhoid patients with pulmonary complications. This last fact should be emphasised in order that spread of the disease by this means may be prevented. R.

Multiple Malignant Tumours and Echinococcus Cysts in a Cirrhotic Liver.—Necker reports the case (*Zeitschrift für Heilk.*, 1905—XXVI.) of a man, aged 59, who was admitted to hospital suffering from abdominal pain. He was anasarcous, and presented all the symptoms of ascites. By aspiration 6 litres of fluid were removed from the abdominal cavity, but coma rapidly set in, and the patient died the next day. At the necropsy more fluid was found in the abdomen; both lungs showed pneumonic consolidation in patches. In the diaphragm there was an elastic tumour, the size of a nut, which on section was found to be white and of firm consistence. Similar tumours were found in the stomach, mesentery, omentum, and intestine. A tumour about the size of a goose-egg was also found in the under part of the right kidney. The liver was firm and irregular on the surface. Close to the diaphragmatic tumour a lump was seen in the liver about the size of an apple, and white in colour; beside this there was a yellowish tumour of different appearance, and near the gall-bladder there was a cystic tumour. On section numerous greyish-white nodules were seen, and many bands of connective tissue. The liver tumours turned out to be: (1) echinococcus cysts; (2) primary adeno-carcinoma of the liver cells; (3) sarcomata. The sarcomata were regarded as secondary to the tumour of the kidney, and were identical in appearance with the tumours in the stomach and mesentery, while the carcinomatous nodules were thought to have arisen from an attempt at compensatory hypertrophy of the liver cells, such as is often seen in cases of cirrhosis. Multiple malignant tumours of different histological appearance recurring in the same organ are very rare, and the author has only been able to collect 29 cases in all from the literature. M.

Multiple Cavernous Hæmangiomata of the Intestine.—MacCallum describes a specimen (*Johns Hopkins Hospital Bulletin*, August, 1906) illustrating the above indicated condition, and gives a summary of the literature bearing on the subject. The specimen was obtained from a patient who had been a constant drinker, and who died of broncho-pneumonia. Chronic pancreatitis, early cirrhosis of the liver, and general arterio-sclerosis were also found at the post-mortem. Throughout the small intestine one could see and feel small, firm areas, blackish-purple in colour, situated along the course of the veins, and reaching a diameter of from 7 to 8 millimetres. On cutting into them and squeezing out the blood, a spongy tissue was left, while microscopical examination showed them to be composed of a sort of cavernous tissue, the spaces of which were lined by endothelium. The veins in the neighbourhood of the nodules were both large and numerous. Apparently only one other case of this nature has been recorded, and that quite lately, but occasionally single cavernous angiomata, reaching the size of an almond and larger, have been noted, and have been the cause of intestinal and gastric hæmorrhage. In the other case resembling MacCallum's, and described by Benecke, the nodules were not limited to the small intestine, but were also present in the stomach and œsophagus. M.

Periarteritis Nodosa.—Under this heading Versé describes (*Münch. Med. Woch.*, 1905, No. 38) a patient who was admitted to hospital with dyspnœa, cyanosis, and general œdema. The temporal artery was much curved, and was very full; lungs normal; heart enlarged; pulse hard, irregular, and of high tension; slight albuminuria. Four weeks after admission the patient died, the clinical diagnosis being chronic nephritis, cirrhosis of liver, and peritonitis. At the autopsy most of this was confirmed. The peritonitis had arisen from two large perforations of the ileum. The small arteries of the mesentery were thrombosed and formed solid bluish-black cords. They were covered over with small nodular swellings of a similar colour, and about the size of peas. These on section turned out to be thrombosed aneurismal dilatations. The general thrombosis had caused necrosis of the intestinal wall and ulceration. Similar dilatations were found in the vessels of the colon, stomach, liver and spermatic cord and heart, the changes in the coronary arteries being probably accountable for some of the symptoms. Altogether about 20 cases of this nature are on record. The process develops as follows:—In the adventitia and outer part of the media of the arteries an inflammatory exudate occurs; this is gradually replaced by granulation tissue, which in contracting destroys some of the muscle of the media, and the process ultimately extends to and involves the internal elastic lamina. The vessel, thereby weakened, yields before the blood pressure, and numerous aneurisms result, the wall of each being mainly composed of cells, fibrin, and connective tissue, with remnants of muscular and elastic fibres. The etiology is unknown, but probably the most important cause is really syphilis. M.

The Physical Relations of Sugar in the Blood.—Asher and Rosenfeld (*Central für Phys.*, 1905, No. 14, S. 449) have investigated this question in order to decide whether sugar exists in a combined or in a free state in the blood. They have found that in all cases sugar is capable of dialysing out of sugar-containing blood, and of behaving, as far as dialysis is concerned, in exactly the same way as ordinary sugar solutions. Their results did not in any way suggest that it was combined with other substances, but showed that it existed in such a physico-chemical state as to still retain its property of diffusibility. The question therefore arises why sugar does not normally appear in various secretions, and the answer to this lies, according to the authors, not in physical, but in vital phenomena. They believe, in short, that the urine does not normally contain more than appreciable quantities of sugar, because the renal cells are capable of restraining actively its passage. M.

Growth of Lymphatics in Granulation Tissue.—This subject has been studied by Coffin (*Johns Hopkins Hospital Bulletin*, August, 1906). He points out that, while the development of lymphatics in the embryo has been fairly well worked out, practically no work has been done on the growth of these channels in the regeneration of connective tissue in the adult. Owing to the ease with which the intestinal lymphatics can be injected through the subserous tissue, granulation tissue was made to grow on the intestinal peritoneum in animals by drawing out a loop of intestine and sewing it to the wound in the skin. After about a week the loop was usually well covered with granulation tissue, and the animal was then killed and the injection performed. In this way it was shown that new lymphatic channels spring from those present in the tissue, and advance into the neighbouring new-formed tissue. The lymphatic sprouts resemble closely sprouting blood-vessels, and beyond the lumen of the channels the endothelial cells are continued in a single or partly double row for a short way. The channels are perfectly sharply outlined, and are completely formed of endothelial cells, standing in no more intimate relationship with the crevices of the connective tissue than do the blood capillaries. M.

We are not greatly impressed with the new monthly publication, *The Prescriber*, the first number of which is before us. It consists of four pages of matter, and we regret being unable to sum up its merits as *multum in parvo*—in fact, the multum is conspicuous by its absence.

NOTICES TO CORRESPONDENTS, &c.

☞ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to 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 proofs.

CHANGE OF OUR OFFICE ADDRESS IN DUBLIN.

The Dublin Office of this Journal has been removed within the past week from 16 Lincoln Place to 18 Nassau Street. The latter premises are larger and more suitable, and will be open from ten to six daily, and on Saturdays from ten to two. Subscribers to the Journal and others desiring information regarding vacancies, *iccum tenentes*, and medical matters in Ireland generally, can always obtain it by applying to the Manager either by letter or personally.

BIOLOGIST.—The origin of the acoustico-facialis ganglion has not so far as we can trace, been made out in mammals.

DR. S.—In 1903, 628 patients were treated at the Pasteur Institute for rabies, with two deaths, and in 1904, 755, with three deaths. We cannot find any later official returns.

R. S.—The saying that "gout is to the arteries what rheumatism is to the heart," we believe is an adaptation of a phrase used by a French physician.

SUBSCRIPTIONS.

SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance.

ERRATUM.—The presidental address on "The Diagnosis of some forms of Dyspepsia," which appeared in our last issue was delivered before the Glasgow Eastern Medical Society by Dr. Thos. C. Barras, not by Dr. Wm. C. Barras as erroneously printed.

WELSHMAN.—The National Anti-vivisection Society was founded in 1875; the British Union for Abolition in (about) 1898.

MOTOR-CARS OF MEDICAL MEN.

THERE appears to be a little confusion in the minds of some owners of motors, judging by enquiries that reach us. Under the existing Motor-car Act, which has been temporarily prolonged, the owners of motor-cars are called upon to pay (1) for a licence to drive, (2) a registration fee, (3) a carriage tax of £2 2s. for cars under one ton weight, and of £4 4s. for cars over one ton in weight. It is probable in the near future these fees will be increased, unless some relief is granted specially to medical men.

Mr. C. H. S. (Brighton).—The demand on our space is so great at present that we are unable to insert further correspondence on the subject.

D.S.S.—The subject is scarcely within our province, but we will look into it.

CONSULTANT.—It would be better not to see the patient again without a distinct understanding. If he comes unasked there would be no reason why he should not be seen, on the understanding that his own attendant is written to.

L. T. P.—Claude Bernard was born 1813 and died in 1878. His first paper on vaso-moter nerves was read before the Société de Biologie in 1851.

THETA.—A paper on Ortho-Diagraphy appeared in the June number of *Medical Electrology and Radiology*. It is by Dr. Paul Kranse.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, OCTOBER 31st.

BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY (20 Hanover Square, W.).—5.30 p.m.: General Meeting to Discuss the Report of the Delegates concerning the Proposed Amalgamation of Medical Societies. 6 p.m.: Ordinary Meeting. Address:—Mr. H. Shirley-Jones (Droitwich) (President): The Art of Medicine in Ancient Egypt.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. P. Paton: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. G. A. Sutherland: The Treatment of Rickets.

THURSDAY, NOVEMBER 1st.

NEUROLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street).—9 p.m.: Address:—Sir Thomas Barlow, Bart.:—Remarks on Some of the Nervous Complications of Specific Fevers.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.)—4 p.m.: Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m.: Lecture:—Dr. C. O. Hawthorne: The Field of Vision in Health and Disease.

LONDON SCHOOL OF CLINICAL MEDICINE (Dreadnought Hospital, Greenwich).—2.30 p.m.: Operations. 2.30 p.m.: Dr. G. Bankin: Medicine. 3.15 p.m.: Sir W. Bennett: Surgery. 4 p.m.: Mr. M. Davidson: Radiography. Out-patient Demonstrations:—10 a.m.: Surgical and Medical. 12 noon: Ear and Throat.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square).—6 p.m.: Chesterfield Lecture:—Dr. M. Dockrell: Seborrhœa and Psoriasis dealt with as Stages of the same Dermatitis in Symptoms, Diagnosis, and Treatment.

FRIDAY, NOVEMBER 2nd.

WEST KENT MEDICO-CHIRURGICAL SOCIETY (Royal Kent Dispensary, Greenwich Road, S.E.).—8.45 p.m.: Paper:—Dr. A. E. Giles: Some Observations on Uterine Fibroids.

SOCIETY OF ANÆSTHETISTS (20 Hanover Square, W.).—Paper:—Dr. Silk: Anæsthesia in Abnormal and Constrained Positions.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC.—4 p.m. Dr. H. Tilley: Clinique. (Throat.)

LONDON SCHOOL OF CLINICAL MEDICINE (Dreadnought Hospital, Greenwich).—2.30 p.m.: Operations. 2.30 p.m.:—Dr. R. Radford: Medicine. 3.15 p.m.: Mr. McGavin:—Surgery. Out-patient Demonstrations. 10 a.m.: Surgical and Medical. 12 noon: Skin.

SATURDAY, NOVEMBER 3rd.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith Road, W.).—10 a.m. Diseases of the Throat, Nose, and Ear. 2 p.m.: Medical and Surgical Clinics. 2.30 p.m.: X-Rays. Operations.

LONDON SCHOOL OF CLINICAL MEDICINE (Dreadnought Hospital, Greenwich).—2.30 p.m.: Operations. Out-patient Demonstrations. 10 a.m.: Surgical and Medical. 11 a.m.: Eye.

Vacancies.

Down County Infirmary.—House Surgeon. Salary £60 per annum, with board, &c. Immediate application to D. Smith, Registrar. See advt.

Grimsby (County Borough).—Medical Officer of Health. Salary £500 per annum. Applications to W. Grange, Town Clerk's Office, Great Grimsby.

St. Bartholomew's Hospital, Rochester.—House Surgeon. Salary £110 per annum, with board and residence at the hospital. Applications to Frederick F. Smith, Clerk to the Trustees, 42 High Street, Rochester.

Clayton Hospital and Wakefield General Dispensary.—Senior House Surgeon. Salary £120 per annum, with board, lodging, and washing. Applications to the Hon. Secretary, Clayton Hospital, Wakefield.

Barnstaple.—North Devon Infirmary, Devon.—House Surgeon. Salary £100 per annum, with board, residence, and washing. Applications to the Chairman, House Committee.

Barnsley.—Beckett Hospital.—House Surgeon. Salary £100 per annum. Applications to Ralph F. Pawsey, Hon. Sec.

Nottingham City Asylum.—Junior Assistant Medical Officer. Salary £150 per annum, with apartments, board, &c. Applications to the Medical Superintendent.

Sheffield Royal Infirmary.—Secretary. Salary £400 per annum. Applications to the Chairman at the Infirmary.

County and City Infirmary, Waterford.—House Surgeon. Salary £100 per annum, with board, &c. Applications to E. O'Farrell, Secretary. (See advt.)

Fermanagh County Hospital.—House Surgeon. Salary £52 per annum. Applications to C. Wilson, Secretary. (See advt.)

Appointments.

CURTIS, H. J., B.S., M.D.Lond., F.R.C.S.Eng., Assistant Surgeon to the Metropolitan Hospital, Kingsland Road, N.B., and Clinical Assistant to the Throat and Ear Departments of the London Hospital.

FARNCOMBE, EDGAR LEONARD, M.B., B.Ch.Oxon., Deputy Medical Officer for the Chudleigh District by the Newton Abbot Board of Guardians.

FLEMING, ROBERT JAMES, M.B.Irel., Medical Officer to the Central District of the Devonport Union.

JACOBSEN, G. O., M.R.C.S., L.R.C.P.Lond., Certifying Surgeon under the Factory and Workshop Act for the Arnesby District of the county of Leicester.

KENNEDY, J. M. P., L.R.C.S.Irel., L.K.Q.C.P.Irel., Certifying Surgeon under the Factory and Workshop Act for the Tullamore District of King's County.

KENSINGTON, Miss E. GLADYS, M.B., B.S.Lond., House Surgeon to the Royal Free Hospital.

KLUMPP, ERNEST GEORGE, M.B., B.S.Durh., Medical Officer of Health for the Cricklade and Wootton Bassett (Wiltshire) Rural District Council.

LATHAM, HENRY, M.B.Edin., C.M., B.Sc. (Public Health), Physician to the Peterborough Infirmary.

LEDINGHAM, ALEX., M.D., D.P.H.Aberd., Medical Officer of Health of the county of Banff.

MCCASKIE, H. B., M.B.Cantab, M.R.C.S., L.R.C.P.Lond., Clinical Assistant to the Chelsea Hospital for Women.

MENCE, W. C., M.R.C.S., L.R.C.P.Lond., Certifying Surgeon under the Factory and Workshop Act for the Perranporth District of the county of Cornwall.

ROSS, J. MURRAY, M.B., B.S.Durh., Clinical Assistant to the Chelsea Hospital for Women.

WALTERS, H. P., L.R.C.P.Lond., M.R.C.S., Medical Officer for the Chudleigh District by the Newton Abbot (Devon) Board of Guardians.

Births.

ALLAN.—On Oct. 25th, at Ardrossan, the wife of W. Carrick Allan, M.D., of a daughter.

MAYBURY.—On Oct. 20th, at Hampshire Terrace, Southsea, the wife of Lysander Maybury, M.D., M.Ch., of twin sons.

POLLOCK.—On Oct. 19th, at Valetta, Malta, the wife of Major C. E. Pollock, R.A.M.C., of a daughter.

SPOONER.—On Oct. 26th, at Coupar House, Blandford, the wife of W. Casswell Spooner, M.B., etc., of a son.

Marriage.

THOMPSON—WANSEY.—On Oct. 27th, at St. Alban's Church, Streatham, Arthur Ralph Thompson, F.R.C.S., Demonstrator of Anatomy, Guy's Hospital, London, and fourth son of Vincent T. Thompson, Esq., barrister-at-law, Leeds, to Florence, daughter of the late A. H. Wansey, Esq. solicitor, Bristol.

Deaths.

CHESMAN.—On Oct 25th, at Llandewy, Radnorshire, Edward Chesman, L.R.C.P., L.M., L.R.C.S., aged 61.

CHURCHILL.—On Oct. 26th, at Netherwood, Guildford, Ellen Louisa, wife of Surg.-General A. F. Churchill.

FURNELL.—On Oct. 27th, at Lee, Emily, widow of William Anthony Purdell, Physician-General Bombay Army, retired.

SMYTH.—On Oct. 26th, at 3 Grosvenor Gardens, Tunbridge Wells, Spencer Thomas, M.D., F.R.C.S.Eng., etc., eldest son of the late Admiral Spencer Smyth, R.N., aged 86.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIII. WEDNESDAY, NOVEMBER 7, 1906. No. 19

NOTES AND COMMENTS.

A "Sporting" Offer.

IN a contemporary last week appeared the following advertisement:—"Man, 31, healthy, interesting medical history, willing to undergo any operation where sporting outside chance of recovery; highest offer; genuine.—Address, &c." As this strange proposition came out in the "agony column," one would have thought it a mere *jeu d'esprit* put in by some practical joker to see what replies it would draw, if the newspaper itself had not sent a representative to interview their sporting patron. The result of the interview duly appeared in the editorial columns, and from it one learns that the advertiser was an ex-soldier, who, after turning his hand to various jobs since he left the Service, is now working on a farm in Somersetshire. He seems to have undergone many vicissitudes, for besides being a soldier and agricultural labourer, he has taken a turn at painting, and even given piano-lessons!

And Morbid Surgery.

THE interesting point for a medical man is to realise that there are people in the world who fancy that surgeons find zest in operating on their fellow-subjects, the sort of morbid delight that Bob Sawyer exhibited in demonstrating his prowess with a loaf of bread and a knife. We do not read of carpenters filling up their spare time by chopping up valuable bits of furniture, or joiners maliciously diverting themselves with tampering with the beams of houses to see how many people will be killed by the fall. Nor, we imagine, do surgeons as a rule spend their leisure in looking out for likely subjects to mutilate. What operation could conceivably be done on a perfectly healthy man, even though furnished with an interesting medical history, passes our comprehension. Perhaps this versatile genius will help us to a conclusion.

A Judge on Advertising Methods.

LAST week there were two important events in connection with improper advertising which ought to put energy into those who, like ourselves, desire to see a proper supervision kept over announcements made for the purpose of trade. At the Old Bailey, Judge Rentoul, in sentencing some American swindlers to penal servitude, said certain organs of the press, whether intentionally or not he could not say, had assisted the prisoners in their operations. A leading article had appeared in a prominent financial journal which praised the company, and, said the judge, if the paper had been imposed upon it was their duty to remove the writer of that article from their staff altogether. Counsel for the paper said that an action was pending against his clients on this score, but that they had acted *bona fide* and would welcome any action brought. The judge made the interesting suggestion that if the papers which had inserted the advertisements would help to recoup those who had been swindled, he would lay the matter before the Home Secretary to see if he would reduce the prisoners' sentences.

And Press Responsibility.

Now, this responsibility of the press is one of the hardest points to bring home with regard to quack advertisements. However obviously fraudulent these may be, the newspapers shrug their shoulders and say it is not their business to enquire into claims of the goods advertised, and they leave it to the judgment of their readers. Now not only does the case mentioned show the judge's opinion on the negligent admission of advertisements, but in another case the editor of a paper was actually convicted of publishing improper advertisements. The cheap press that circulates in the houses of the poor and lower middle classes knows perfectly well that its clients have not sufficient discrimination to distinguish between the "catchy" fraud and the genuine article, and in publishing misleading advertisements it undoubtedly renders itself *particeps criminis*.

The Business Side of Medical Practice.

THE straitened incomes of medical men are still providing a burning topic for Fleet Street. A vast quantity of printer's ink has been shed, but the flood of correspondence shows no signs of abating, and those who take the trouble to follow the subject will be rewarded by many a caustic comment and shrewd observation. One gentleman, who signs his name in full over the letters, "M.D.Lond.," contributes a letter of three-quarters of a column to the *Standard*. One of his main points is that the profession of medicine must be approached on a business footing. £1,000 must be devoted to education, and £500 to the purchase of a practice, or to the cost of working one up. We should say that in the majority of cases the sums mentioned are insufficient for the purpose. We heartily agree, however, that the medical man who starts in

practice without being able to command the requisite amount of capital is thereby heavily handicapped at the outset of his career. Ordinary prudence dictates the same amount of caution that regulates the choice of law, divinity, or the public services as a means of gaining a professional livelihood.

High Aims and Empty Pockets.

ENTHUSIASM and learning will not compensate for the lack of initial capital. It is true they are invaluable aids in developing a practice, but they fail when it comes to the question of laying the foundations. The crucial period for the beginner is that spent in waiting while the grist comes to the mill, and that is precisely where the shoe pinches in so many instances. Too often the enthusiast has to learn in the school of bitter experience that the mere nobility and self-sacrifice of his professional life will not bring him a living. On the other hand, anyone with an average amount of brains and a moderate capital can make sure of a fair income as a medical practitioner. Indeed, the command of an independent income confers comfort in general, and confidence in consulting and special practice, while it is almost an absolute essential nowadays for the prosecution of long-continued original research work.

LEADING ARTICLES.

FOOD INSPECTION.

OF late the public mind has been much exercised upon the purity of its food supplies, to which their attention has been somewhat forcibly directed by the American "tinned meat scare." If the spirit of wholesome enquiry be thereby stimulated the work of the sensational novelist, Mr. Upton Sinclair, will not have been altogether wasted. Briefly stated, he asserted that in the United States certain firms concerned in the preparation of preserved meats carried on their business under conditions seriously menacing to the health of the consumer. As America does a large export trade in the canned meat sent to the United Kingdom, these alarming statements naturally caused a profound sensation on this side of the Atlantic. Results were immediate and far-reaching. American tinned goods fell to zero prices, and that particular trade still reels under a blow from which it will take some time to recover. The moral of the exposure is that in the long run it is only honest and upright trading that can endure. Only those American manufacturers who have kept their house in order have been able to defy criticism, and will continue in the uninterrupted enjoyment of a great and lucrative trade. But the scare has had a good effect in causing the public health authorities of the United Kingdom to look more closely into their own methods. There can be little doubt that the food supplies of our own country are subject to a vast amount of adulteration and of dangerous contamination of various kinds. There is no such thing as a proper scientific control of the many slaughter-houses, and meat markets, and the resulting damage to the community must in the aggregate be indeed great. The law affecting the control of food is in many ways contradictory, anomalous, insufficient, and altogether unsatisfactory. Public health authorities have not yet made up their minds upon so simple a point as to whether tuberculosis is spread by the flesh and milk of tuberculous animals. So that a probable source of contamination, to state the case mildly, is going on unchecked in our midst. Of what use is it building princely sanatoria to treat a few better-class consumptives when we have not taken the trouble to ascertain so elementary a fact in the causation of the malady? This attitude demonstrates to perfection the want of logic in many of our insular notions. However, some light gleams through the melancholy darkness when we reflect that in spite of faulty methods of popular reasoning British sanitation has hitherto led the van among the nations of the world. Presumably there is something in the common-sense national grip of affairs that has instinctively seized upon and enforced the essentials of the situation. Nevertheless, it is to be hoped that in the near future a somewhat larger measure of science may be introduced into our methods. In the matter of meat inspection, for instance, would it not be infinitely wiser to have a band of scientifically-trained inspectors, who would have, as in Germany, command of laboratories, furnished with all necessary modern appliances of physical, chemical, and bacteriological investigation. As a rule the British meat inspector, when he exists, is a man absolutely without scientific training, to whom a miscroscope or a culture tube would be as much a thing unknown as to a negro of Central Africa. We are glad to see that the medical officers of health are turning their attention seriously to the necessity of a closer supervision of our food supplies. At their recent annual meeting an able paper was read upon the subject by Dr. George Newman, medical officer for the Finsbury District of London. He first of all very wisely advocated certain reforms that are urgently needed in the law. Among many other important things advocated by him the following may be specially noted: After seizure of suspected articles careful examination should be made by the medical officer of health, full notes taken of the pathological condition of the meat, and before any further proceedings are taken the vendor should have ample means of examination. There should be a gradual extinction of private slaughter-houses and a rigid system of marking and stamping all inspected meat, home or foreign. Foreign meat should be required to comply absolutely with English standards, and there should be some guarantee that the meat had passed a proper inspection, and no boxed, boned, or pieces of meat should be admitted if packed or prepared in a way to prevent inspection. More adequate inspection of tinned meats and similar foods is urgently needed. There is evidence of much unwholesome preparation by no means confined to America. Even in London he had come across tuberculous pus put into widely advertised sausages, diseased horseflesh into potted meat, and decomposing animal matter into potted salmon and shrimp. The only way of effective administrative control of the preparation of these and various other foods is by inspection

at the time of manufacture of the constituents of the prepared foods and of the premises, and there should be a distinctive inspection mark. Name and date of canning should be stamped on every tin. The regulations necessary for the protection of the consumer would require fresh legislation. Fish, oysters, ice-cream, watercress, milk, eggs, and other articles require the exercise of scentific common-sense control in all stages of storage and distribution. Of a truth Dr. Newman's remarks seem calculated to awake the echoes in many a municipal quarter. Those who are interested in the subject—and who is not?—should make a careful study of the article in the original.

A STATE MEDICAL SERVICE FOR IRELAND.

THE first volume of the report of the Commission to consider the working of the Poor-laws in Ireland is one of the most important documents issued for some time. The Commission has been working for the past three years, and has collected an enormous amount of evidence which will be published in a later volume. The Commissioners have made a very large number of recommendations, many of which are of a sweeping character. We shall refer to the majority of these in another place, but here we desire to draw public attention to one which, in our opinion, possesses the greatest interest for medical men in Ireland. The Commissioners unanimously recommend a complete reorganisation of the Poor-law Medical Service. A State medical system is advocated, the entrance to which, at all events for the present, should be restricted to candidates educated in Ireland. A competitive examination for entrance should be held and conducted on lines similar to those for the Navy and Army Medical Services. The Service should be controlled by a Council composed of five members as follows:—The Medical Commissioner of the Local Government Board, a representative of the Royal College of Physicians and of the Royal College of Surgeons in Ireland conjointly, a representative of the Irish Branch of the General Council of Medical Education and Registration of the United Kingdom, a medical representative from the University of Dublin, and a medical representative from the Royal University of Ireland. Our readers do not require to be told that this is a reform the necessity of which has long been urged in these columns. The present system of electing medical officers in the Poor-law Service is nothing short of an insult to the profession, and is derogatory to the self-respect and medical qualifications of the applicants. We are quite aware that the proposal of the Commissioners will give rise to considerable difference of opinion, and for this reason we appeal to the medical profession in Ireland to give the matter their serious attention. Can any member of the profession conscientiously say that under the present system the medical qualifications of the candidates receive due consideration? Can he say that the conditions under which the newly-appointed medical officer holds his post are such as are due to a man who has spent hundreds of pounds and five years of his life in learning his work? Can he say that the future prospects of the medical officer are those to which his education and a faithful discharge of his duties entitle him to look forward? Can he, in short, give any reason save one why the present system is worthy of continuance? The opponents of a state service will bring forward the old objection that the power of electing should not be removed from "the people," and that no change was sought when the mode of election was vested in the old Dispensary Committees. They will further say that medical officers would find themselves far worse off in a State Service than at present. The first objection is scarcely consistent with the present trend of opinion in Ireland. The very people who object loudly to a State Medical Service, with competitive entrance, are those who cry equally loudly for the creation of competitive examinations for clerkships in railway companies and such commercial undertakings. Why should what is right in one case be wrong in the other, when the conditions are almost identical? The second objection cannot stand examination any more successfully than the first. If any man thinks that it is tenable, will he compare the conditions under which a medical man lives and discharges his duties in the Public Services and in the Poor-law Service. To the one he is appointed on his professional qualifications and on those alone; he receives a salary on which he can live from the day he enters the Service; his salary increases by regular increments; and when he has served for the necessary term of years, he receives a gratuity or pension and is allowed to retire. Look at the other side of the picture. The candidate for a post in the Poor-law Service knows that his professional attainments will be the last matter considered by the electors; he receives a starvation salary; save in a few cases, no regular increments of increase are assured; and even when, from no other cause than old age, he has become incapable of working, his chances of a pension are but small. When medical officers are advised to oppose a State Service, we urge them in their own interest to consider the question well, to contrast the conditions in their own Service and in the Public Services, and to refuse to be guided by the professional politician.

NOTES ON CURRENT TOPICS.

The Treasury and "Professor" Richard.

THE successful prosecution of the notorious electrical quack, "Professor" Richard, at the Stafford Assizes last July was hailed by the MEDICAL PRESS AND CIRCULAR as a hopeful sign of the times. The Watch Committee of the Wolverhampton Town Council appointed a sub-committee to consider the question of costs. A representation was subsequently made to the Treasury, drawing attention to the great public importance of the prosecution, and to the fact that witnesses had been brought from all parts of the country.

In the face of these facts it was urged that to throw the whole of the costs upon Wolverhampton would be unfair. It is most satisfactory to be able to announce that the Treasury have adopted that view of the case, and have agreed to pay the whole of the expenses, amounting to about £500. The official attitude is a most hopeful and encouraging feature of the case. Were prosecutions of quacks to take place on any systematic and general scale the country could be cleared of these pests of society within a few years. Obviously the knowledge that they themselves would have to pay the costs of prosecuting any quack, however injurious and fraudulent, who might settle in their midst would make many a local authority hesitate to saddle their ratepayers with a burden in defence of what are really the interests of the community.

Placenta or Blood Clot.

A CASE of some importance to medical practitioners was recently investigated in the East Ham Coroner's Court. A young married girl, sixteen years of age, died after being attended in her confinement by a certificated midwife from a nurses' home. A *post-mortem* examination was made by a Dr. Bourke, who stated that he found a great portion of the placenta in the womb. Evidence to a contrary effect, however, was given by Dr. John Phillips, described in the newspaper reports as "an expert," who gave his opinion that the supposed placenta was a clot of blood that had led to septic poisoning. Dr. Bourke thereupon produced a report from the Clinical Research Association to the effect that the specimen submitted to them was placental structure, and he offered the Coroner a microscopical slide for his own satisfaction. The jury returned a verdict of death from natural causes. The Coroner has refused to re-open the case. From various points of view the results of the investigation are far from satisfactory. Dr. John Phillips may have good reasons for arriving at his declared conclusion, upon which the verdict of the jury was based. In the face of the report by the Clinical Research Association, however, it would have been more reassuring if he had furnished some reason for the extraordinary discrepancy.

Bad Oysters and Distinguishing Marks.

A NUMBER of cases of illness arising from bad oysters have been recently reported. In one instance brought under our personal notice a distinguished London physician was attacked with symptoms of severe ptomaine poisoning, fortunately without serious results. This matter of unwholesome oysters has been before the public health authorities of the United Kingdom for many years. It has been fully reported upon by the inspectors of the Local Government Board, who showed that the choicest native oysters from Whitstable, Hayling Island, Southend, and other places were often bedded and stored under filthy and dangerous conditions. Every now and then a scandal arises, usually in connection with a public dinner. The bacteriology of the subject has been adequately studied. Yet in spite of all this knowledge oyster poisoning continues. A similar state of affairs would not be tolerated in the case of any other ordinary foodstuff. The Belgian Government are now advocating the imposition of a mark denoting the place of origin of the oyster. That is the precise step that the MEDICAL PRESS AND CIRCULAR has advocated for many years past. If the Government were to insist upon a distinguishing mark being affixed to oyster-shells there would soon be an end to bad oysters. Meanwhile, the oyster trade has been half ruined, and a few more scares will practically extinguish it altogether.

The Royal College of Surgeons, England.

The annual report of the Royal College of Surgeons, England, can always be relied upon to contain some interesting details in respect to the progress of the College, and the "Calendar" which has just been published for the current year is no exception to the rule. Formerly the most prominent feature which claimed attention was the proceedings in connection with the contest of the "Body Corporate" with the Council, when a powerful section among the Fellows laid hands upon the old-time traditions of the College, and sought to induce the Council to apply for a new charter, in order that there might be less conservatism and more democracy in the government of the College. But for some years now a serenity bred of a satisfied ambition has prevailed between the Fellows and the Council; so much so that the question of reforming the Council by the election of Fellows pledged to democratic views has ceased to be thought of. Still the members, it should be added, have their grievances against the Council, but these, such as they are, are only of service to certain of the agitator members, who are thus afforded an opportunity of making a speech at the annual meeting of Fellows and Members. The most interesting item in regard to the College is the financial statement. The balance of income over expenditure amounts for the past year to £2,329, a most satisfactory record. Seeing the important national duties which the College undertakes, and the valuable fabric which it maintains, it is essentially gratifying to learn how sound is its financial position. There are now on the roll of the College 1,363 Fellows and 17,424 Members, besides 2,016 Licentiates in Dental Surgery, and 578 Diplomates in Public Health.

The Late Mr. George Herring.

BY the death of Mr. George Herring the nation has been deprived of a great philanthropist. In his early days he amassed a fortune of £50,000, which he afterwards converted into millions by legitimate operations upon the Stock Exchange. Always a shrewd business man, he was careful to inquire about the practical side of the charities to which he devoted large sums during his lifetime. His methods might be studied with advantage by many philanthropists, both as to their current and their testamentary benefactions. One of the institutions that benefited most from his generosity was the Hospital Sunday Fund, to which he gave an annual donation of £10,000 from 1899 to 1901. Then he offered to add 25 per cent. to their receipts, up to £25,000. In that way sums varying from £11,000 to £12,400 have been sub-

scribed. In all the Fund has received about £100,000 of his wealth. Mr. Herring was also honorary treasurer of the North-West London Hospital. He built and endowed the Home of Rest for Gentlefolk, the Twentieth Century Club for working ladies, and other charitable organisations. Amongst other things, he handed over £100,000 to the Salvation Army Home Colonisation Scheme. His carefully considered generosity affords an excellent example to benevolent folk, who are apt to think that, having given their money, all further responsibility as to its distribution is at an end.

Lunacy in London.

The Report of the Asylums Committee of the London County Council for the year ending March 31st, 1906, was issued last week, and to the scaremongers who have been trying to frighten people into the belief that national insanity was merely a matter of time, this volume will act as a check. We have frequently pointed out the many causes at work which have produced the increase in the numbers of the certified insane, the chief of which is the disposition of the poor to send their old people suffering from senile decay to the asylum. Although this action may bespeak a lack of independence on their part, it is a high testimony to the improved conditions of asylum life. Moreover, as the large outstanding number of senile dements becomes absorbed into the normal asylum population, the rate of increase of lunacy must drop. This process, which began in London last year, is much more plainly visible in the present report, the actual numbers of persons in asylums for the last five years being:—

		Increase on previous year.
1902	21,255	786
1903	22,052	797
1904	23,948	996
1905	24,652	704
1906	24,957	305

Thus it will be seen that whereas the increase in 1904 amounted to nearly a thousand, this year it has fallen to only just over three hundred. Unless some unforeseen improvement occurs, one must expect, in a population growing so rapidly as that of London, a normal increase in the number of the insane. It is comforting to find that the rate is decreasing so satisfactorily.

Windsor District and its Drainage.

The district of Windsor is perhaps one of the wealthiest in the country, the neighbourhood, besides being particularly pleasant, offering to rich people the advantages that flow from proximity to Royalty. Under such circumstances one would have imagined that the amenities of life would have been specially cared for by the inhabitants and their representatives on the council. Far from this being the case, Dr. Petronell Manby has lately made a report to the Local Government Board on the sanitary circumstances and administration of the Windsor Rural District, from which one would gather that that smiling countryside has little to boast of beneath the surface. After describing his investigations on behalf of the Board, Dr. Manby writes that the council will have to decide whether they will adopt a drainage system or institute wet-scavenging, which latter will be obsolete in a few years' time, and concludes:—"As the result of a detailed inspection of the district, I am satisfied that the present sanitary condition of Ascot, Sunninghill, and Sunningdale leaves much to be desired." It is wonderful in what respect people hold the outside of the platter!

Medical Reports to Public Officials.

The exact legal and moral relation of doctor and patient is a matter of great delicacy. In private practice questions frequently arise which tax the judgment to the utmost, but in public appointments even more difficulty is experienced. The ordinary common-sense view that the person who pays a doctor for his opinion is the person entitled to that opinion, is not always a safe one to put into practice. A case involving a very delicate point was tried in Glasgow lately. Dr. Boyd, the Corporation Police Surgeon, appears to have diagnosed the illness of one of the constables as of venereal origin, and duly reported his diagnosis in the usual way to the Chief Constable. The constable was indignant, as he denied the accusation, and he brought an action for slander with damages assessed at £1,500. Now, unfortunately, it appears from the report that the diagnosis was doubtful, if not positively mistaken, and Dr. Boyd was consequently placed in rather an invidious position. However, the judge took the clear-sighted view that even if the diagnosis were erroneous, and even if the examination were not sufficiently searching, there was in these facts no evidence of malice or recklessness. The case was therefore dismissed. It is most desirable that a medical man's position in relation to confidences of this kind should be rigidly defined.

H.R.H. Princess Louise has consented to open the new wing of the London Throat and Ear Hospital, on November 13th.

Mr. Richard F. Tobin, F.R.C.S.I., has been appointed by the Lord Lieutenant to be Secretary to the Board of Superintendence of Dublin Hospitals. Mr. Tobin is an ex-president of the Irish Medical Association and Surgeon-in-Ordinary to the late Viceroy.

Dr. E. G. Thomas, late civil surgeon to the Guards Depot, Caterham, on the termination of his appointment, has been the recipient of a presentation by the officers of the Brigade of Guards and other friends.

Dr. Thomas Reid was recently entertained to dinner by a few of his old house surgeons in the Glasgow Eye Infirmary, and presented with an address congratulating him on having reached his professional jubilee. Dr. Reid was also presented with a silver bowl, and Mrs. Reid with a silver salver.

Our Scotch correspondent writes us that the Glasgow Town Council at its meeting last week was the first authority to make consumption a notifiable disease.

A CLINICAL LECTURE ON LATENT DISEASES. (a)

By Professor POTAIN, M.D.,

Of the Faculty of Medicine and University of Paris.

By latent diseases we mean diseases the existence whereof is hidden from the physician and the patient by reason of its insidious onset or because it assumes the characteristics of some other malady. Here is a case in point.

A woman was recently admitted into my wards with cardiac dilatation. She had been under my care in 1894 for rheumatic endocarditis. While she was in the hospital the heart was very carefully examined with the following results: There was at first blurring, then disappearance of the second sound with the appearance of a systolic murmur. The nature and the seat of the changes indicated the existence of inflammation of the aortic and mitral valves. The lesion of the aortic valve was of short duration and the sounds gradually returned to their normal pitch. Only the mitral *souffle* persisted, and it was not very loud. That was her state when she left us.

But now she presents all the signs of pronounced cardiac hypertrophy. This fact was of a nature to cause surprise, because the mitral murmur, never very well marked, pointed to a lesion too slight in itself to determine so much hypertrophy. Dilatation of the heart, as you know, only occurs quite late in mitral disease, just the contrary to what happens in aortic mischief. We were therefore fain to seek some other explanation for this dilatation. The patient died from heart failure, and at the *post-mortem* the necessary explanation was forthcoming in the existence of extensive adhesion of the pericardium, which was glued together by thick, tough, quasi-cartilaginous fibrous tissue. The mitral valve, much deformed, showed many milky patches. The water test showed leakage limited to two spots. In addition to the valvular insufficiency there was slight narrowing due to adhesion of the valve segments over an area of a few millimetres. This is usual, for in almost every instance mitral insufficiency is associated with some degree of narrowing.

The principal lesion in this patient, then—that which determined the cardiac dilatation, which was the only perceptible symptom during life—was the pericardial adhesion. It ran quite a latent course, and this proves the importance of being on the look-out for latent diseases. I propose to go into this subject somewhat in detail.

On thinking the matter over, the first thing that strikes one is the importance of the semiology. Every disease is recognised by its own particular symptomatology, and it is to these symptoms that we must look for guidance. It is, however, not enough to know that such and such a disease is manifested by such and such symptoms. We must distinguish those symptoms which are common to other diseases and seek the means of differentiating them in each case.

Symptoms may be divided into two main classes: (1) functional, (2) physical. The functional signs consist in disturbances of the organism, and these are the symptoms which first attract the attention of the patient and lead him to seek advice. The physical signs are those which the physician alone can detect and identify, and these he only looks for when the functional signs suggest the probability of this or that morbid process.

With respect to semiology the medical science of to-day differs greatly from that of the past. Our forefathers in the art knew practically nothing of physical semiology, which only occupied an insignificant place in the art of the physician who was not in possession of the means of elucidating them. At present we are in possession of these means, and our methods of exploration have been so multiplied and perfected that the study of physical signs has acquired an immense and deserved importance.

Our knowledge of the physical signs of disease does not go so very far back. We ought possibly to mention the works of Auenbrugger on percussion, translated by Corvisart in 1808, but the work was done for the most part by Lænnec, who in two years created, so to speak, a new and complete science, almost unknown to his predecessors, *viz.*, the science of auscultation. Physical semiology, you see, only dates back about a century, which is but a brief period in an art of which Hippocrates was the father.

Although antiquity was inferior to ourselves in the matter of semiology, you must not run away with the idea that our forefathers despised the investigation of the objective signs of disease. Hippocrates strove perseveringly to discover the signs of changes in the organs, and if he does not give us the means of establishing the existence and the significance of physical signs he at any rate pointed out the object we must have in view, which consists in observing in the patient "everything that can be seen or heard or smelled." Are not these the desiderata furnished by percussion, inspection and auscultation?

It is no exaggeration to state that Lænnec founded a new science. Instruments *per se* do not constitute a progress. Auscultation and percussion can exist very well without the invention of the stethoscope and the pleximetre. Auscultation and percussion are real sciences, and if the ancients did not discover them, it was because they lacked the knowledge which is the indispensable corollary of the investigation of physical signs, *viz.*, a knowledge of pathological anatomy. Now pathological anatomy did not exist in antiquity for the simple reason that dissection of the dead was not permitted. Rondelet, of Montpellier, was the first to examine the bodies of dead patients. Charles Bonnet, in 1779, it is true, made observations in pathological anatomy, but he only called attention to certain curious facts: "a stone in the brain," "a bone in the heart," and so on. Pathological anatomy can only be said to have become an exact science in the hands of Dupuytren, Cruveilhier and Lænnec, who looked upon these researches as inseparable from the study of semiology. How, indeed, can we discover the physical signs unless we know in advance to what lesions they correspond?

Of course, in the present state of our science we cannot expect to find physical signs in diseases of inaccessible organs such as the brain and spinal cord, for which reason there will always be plenty of scope for functional signs. But the latter may be wanting, and so you will understand how certain diseases may remain latent for a longer or shorter time, sometimes till death, running their insidious course in the tissues without giving rise to any subjective or objective signs.

Latent diseases may be divided into three categories: (1) latent diseases, properly so-called, which reveal their presence by no functional or physical sign; (2) undeveloped diseases; and (3) diseases which are masked by or simulate other diseases.

Among diseases which belong properly speaking to

(a) An unpublished lecture by the late Professor Potain, specially reported for this Journal.

the group of latent diseases—*i.e.*, which most readily escape our observation—may be mentioned cerebral tumours, cancer of the kidney, cardiac symphysis, ulcer of the stomach, and renal calculi. At the museum of Montpellier is a specimen removed from a man who died without having presented any cerebral symptoms, although as a matter of fact a dagger had penetrated the brain after passing through the skull. It is by no means uncommon in old people to discover stones in the kidneys which have never given rise to any obvious symptoms. I can recall an instance in which a large calculus embedded in, and quite filling, the kidney pelvis was never suspected during life. Miliary tuberculosis of the lung may run a silent course, witness the case reported by Kelsh in which he made the *post-mortem* examination of a man "in excellent health." Pericardial adhesion and pleural adhesion may both remain "latent" for long periods of time, and the same remark applies to chronic atrophic nephritis which sometimes runs a dumb course until it culminates in an attack of uræmia.

Many affections based on an atrophic lesion, stricture &c., can only manifest themselves in consequence of an effort which directs attention to the diminution of functional capacity. For instance, Gibert, of Havre, remarked that infants with intestinal stricture remain in good health so long as they live on milk, but as soon as they begin to take solid food their troubles commence.

To this state of reduced functional capacity I give the name "Miopragia" from the Greek *meion*, deprivation.

Mitral stenosis sets up a state of circulatory miopragia which does not cause trouble until an unusually strong effort determines a much larger stream of blood.

Among undeveloped diseases I may mention persistent diarrhœa of malarial origin. I have seen many such which yielded only to quinine. Malaria, indeed, assumes many other masks.

The predominance of one particular symptom may lead us into error. In a case that came under my observation a certain hospital surgeon was long thought by his colleagues to be suffering from some grave cerebral affection. He was subject to attacks of giddiness so severe that he was fain to cling to the bedposts when going his rounds in order to avoid falling down. Careful auscultation revealed the fact that he had pronounced aortic insufficiency.

The third group—that of masked or simulated diseases—comprises the majority of the cases which differ widely. First, maladies really simulated by hysterical women, or for more serious reasons: marriage, life insurance, conscription, &c. A more interesting group are those in which a disease is masked by a concomitant affection or by a complication, or, simpler still, by a collateral symptomatology that directs attention to a more or less distant organ. I have often warned you of the erroneous interpretations that these various modifications may give rise to, but here are a few examples: You are aware that pulmonary emphysema may mask the physical signs of pulmonary tuberculosis with which it is frequently associated. In the same way great difficulties present themselves when aortic insufficiency is associated with mitral stenosis.

Patients are often ignorant that they are suffering from some gastric affection. A doctor who was troubled by his heart was radically cured by merely washing out the stomach, the cardiac disturbances being directly caused by the unhealthy condition of that organ, in spite of the fact that so far as he was aware his digestion was excellent. It is by no means unusual in such cases for the clinical picture to be that of heart disease, with palpitations, dilatation of the right heart, cardiac liver, ascites, œdema of the lower limbs and syncopal attacks. Yet when we correct the gastric trouble all the cardiac symptoms disappear.

Affections of the stomach, then, may exert such an influence on the circulatory apparatus as to give rise to the suspicion of heart disease, but the converse is equally true, and cardiac disease may be manifested at first merely by gastric symptoms. These facts are of course familiar to you, but there is one symptom of circulatory disturbance that merits special attention—*viz.* diarrhœa. Some patients suffer from persistent refractory diarrhœa without any other trouble or discomfort. We naturally ascribe the symptom to an intestinal affection, whereas our patient may be suffering from heart disease. I recently saw a case of this kind with Dr. Guyot. The patient complained only of obstinate diarrhœa, and on examination I discovered abdominal aneurism to which he succumbed shortly after.

Cardiac affections may simulate a purely hepatic affection when the symptoms are limited to the liver—ascites and œdema. In other instances, especially in mitral lesions, they may present deceptive nervous symptoms.

In gastric affections, too, we sometimes meet with vertigo, migraine, and even typical apoplectiform attacks. I remember a patient who suffered from attacks of this kind whose only trouble in reality was defective teeth with deficient mastication and consequent indigestion. Stomach cough is a symptom we must be on the look-out for, because when it is associated with emaciation we are apt to suspect incipient tuberculosis. We must also bear in mind the gastric origin of pseudo-asthmatic attacks due to bronchial or vascular spasm, or to urticaria of the bronchial mucosa.

Intestinal parasites give rise to the most varied symptoms, In the adult the presence of tænia in the small intestine may lead to mental aberration, kleptomania, &c. As soon as the worm is expelled reason and morality are restored. A naval officer, previously a man of extreme courage, was one day seized with inexplicable fear, so that he dared not weigh anchor. The ship surgeon, surprised at this extraordinary and unusual display of timidity, enquired into the officer's health, and found that he had worms. He administered a vermifuge, and thereupon the officer recovered his normal temperament.

The reaction of intestinal affections on the heart gives rise to strange errors: colitis, for instance, may simulate a heart disease. Hepatic affections have a more or less marked influence on the nervous system, hypochondria being one of the forms. They also give rise to cardiac symptoms and to signs compatible with disease of the lungs. In one case a hydatid cyst of the postero-superior part of the liver gave rise to a dry cough and steady emaciation, leading to the suspicion of phthisis. I recently saw an instance of this in a young tuberculous subject.

Biliary calculi are not infrequently mistaken for cancer of the stomach. Billroth was just about to operate in a supposed case of gastric cancer when I ventured to diagnose calculous cholecystitis. The patient died, and *post mortem* we found a calculus that had determined inflammation of the gall-bladder with consecutive peritonitis. I saw another case with Guéneau de Mussy. The patient, who was of cancerous family history, presented a tumour, and as a matter of fact she died later of cancer. Nevertheless, at the date of our examination she was not cancerous, as was proved by the fact that a season at Aix cured her, and she came back with a bottleful of gallstones passed by her.

On the other hand, certain lesions are manifested by similar symptoms simply because they occupy the same region, in which case the diagnosis may be of extreme difficulty. What can be more difficult, for instance, than to distinguish between cerebral anæmia and cerebral congestion? Andral and Grasset describe their symptoms as being identical. The mechanism of the malady is different, but the effects are approximately the same. In the former, too little blood gets into the vessels, and in the other too much, but the ultimate result—*e.g.*, blood stasis—is the same.

Hæmorrhage and brain softening can only be differentiated by the circumstances in which the disease has supervened. If the patient was previously suffering from atrophic nephritis the evidence would be in favour

of hæmorrhage, whereas if the patient was atheromatous we should opine in favour of softening.

In diseases of the lungs it is often difficult to differentiate cancer from tubercle.

Confusion may also arise between disease of altogether different organs when they happen, as is sometimes the case, to give rise to the same disturbances. Pulmonary congestion gives rise to syncope and apoplexy just as does cerebral congestion. This coincidence is often seen in the aged who succumb to apoplexy, and in whom *post mortem* we find commencing pneumonia. Exactly the same thing happens when large pulmonary emboli suddenly block the circulation.

Tuberculosis at its onset often determines palpitations calculated to make us suspect cardiac disease and so turn our attention from the real lesion. At a later stage this disease may cause the same mistake on account of the dulness over the pre-cardial area, due to the presence of indurated pulmonary tissue, suggestive of cardiac hypertrophy, while the oppression and the œdema of the lower limbs due to respiratory embarrassment may likewise be ascribed to a cardiac lesion. Dulness of the sclerosed pulmonary tissue at the apex may lead to the diagnosis of an aortic lesion.

I need not carry this enumeration further, though I could do so without difficulty. If I have insisted somewhat forcibly on the subject, if I have made a point of bringing before you numerous examples, it is in order to convince you of the importance of a careful exact examination of all cases. You will remember that subjective semiology, fruitful of errors, is for the most part of but slight assistance in arriving at an exact diagnosis, and that the physical signs, of vastly greater importance and significance, must also be carefully scrutinised—in short, that we must always seek to establish the reciprocal subordination of the morbid elements in order to reduce the chances of error to a minimum.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The Lecture for next week's issue will be by J. Magee Finny, M.D., F.R.C.P., King's Professor of the Practice of Medicine, on "Erethema Induration."*

ORIGINAL PAPERS.

SOME NOTES ON FAMILY DISEASES. (a)

By T. K. MONRO, M.A., M.D., F.F.P.S.G.,

Physician to the Glasgow Royal Infirmary, and Professor of Medicine in St. Mungo's College.

GENTLEMEN,—In his presidential address last year, my distinguished predecessor in the occupancy of this chair discussed one of the most important principles connected with the doctrine of inheritance, and after making his own position clear, proceeded to indicate the bearings of the question upon many of the diseases to which mankind is liable. On the present occasion, I venture to bring under your notice a subject which is no doubt intimately connected with the question of heredity, but which lends itself to be introduced by the statement of a very simple theory, which, in turn, can immediately be illustrated by an appeal to clinical experience.

It might seem that the most natural mode of dying is to die of old age, and yet this is one of the rarest modes we meet with. Even those who escape the infections and their results seldom die in this way. No doubt if we could combine the advantages of civilised and uncivilised life, and eliminate the disadvantages of either, this would happen more frequently than it does. But too often a particular tissue or organ undergoes decay prematurely, with the result that the whole organism dies at a time when many of its parts are in good condition and fit for many years' service, or are, at most, altered secondarily to the one that broke down. This premature decay is often seen in the case of the arteries, and while it is frequently due to the disproportionate strain put upon these structures during life, it is well known that certain families shew a strong tendency to sufier from the results of arterial disease (*e.g.*, cerebral hæmorrhage and softening), while other families shew a striking degree of immunity from such evils. But the kind of premature decay to which I wish specially to refer this evening is that which occurs before the age of 40 or 45, when the degenerative period of life may be said to commence in the average individual. For instance, *aneurism* has been met with in different members of a family (*e.g.*, in two brothers) in early adult life. Some of the best illustrations, however, are encountered when we study the diseases of muscles.

In *muscular dystrophy* we see a disease, or group of diseases, which depend on a defective power of development in the tissues from which the voluntary muscles are derived. The developmental power is sufficient for the growth and activity of the muscles for some time after birth, and even it may be for a good many years; but it fails at length, and then the muscular fibres gradually waste away. While this is happening, the interstitial tissue behaves in different ways. It often undergoes an increase, and this may or may not be sufficient to compensate, so far as bulk is concerned, for the loss of the muscular fibres. Sometimes the interstitial tissue flourishes to an extraordinary degree, becomes infiltrated with fat, and actually renders the part more bulky than if it had been absolutely normal. This disease, then, is due in one sense to a congenital defect. It shews itself during the period of growth—some time between infancy and maturity—and it is often met with in several members of one family. In the case of the variety which is characterised by increased size of the weakened muscles (pseudo-hypertrophic paralysis), the usual, though not invariable arrangement is that the males suffer from the disease, while the females transmit it. In the other varieties the sexes suffer almost equally. In the pseudo-hypertrophic type the muscles which are most apt to be enlarged are those of the calves, and next to these the infraspinati, while increase or decrease of size takes place in numerous other muscles of the limb-girdles and proximal parts of the limbs. The first symptom is weakness or awkward use of the lower limbs. The child has a difficulty in going upstairs, falls readily, and has great trouble in rising again. Yet, on examination, the weakened muscles seem well nourished, and may, indeeed, be recognisable as increased in size. One of the most striking features of the disease is the enlargement of the calf muscles and infraspinati, in combination with wasting of the latissimus dorsi and the lower part of the pectoralis major. The wasting and weakness are progressive in their tendency, and in most instances death takes place before the age of 20, very often from bronchitis or pneumonia.

In the juvenile type, the wasting generally shews itself about puberty. It begins in the muscles of the upper arm and shoulder-girdle, and afterwards attacks those of the trunk, pelvic girdle and thigh. The prognosis is not nearly so grave as in the case of the pseudo-hypertrophic type, since the patient may survive for many years.

In the facio-scapulo-humeral or infantile type, the disease may appear either in infancy or at puberty. It usually affects first the orbicularis oris and orbicularis palpebrarum. It may spread over the face, but it spares the ocular muscles and the tongue. Moreover, it spreads to the limbs and trunk like the juvenile type. It also is less grave than the pseudo-hypertrophic variety.

Another form of muscular atrophy, which is entirely distinct from muscular dystrophy, and which yet

(a) Presidential address delivered to the Glasgow Southern Medical Society on October 4th, 1906. Illustrative cases and photographs were exhibited.

commences in early life, and runs in families, is the *peroneal type of muscular atrophy*. Here the wasting is first noticed in certain muscles which are supplied by the peroneal or external popliteal nerve, viz., either the long extensors of the toes, or the peronei, but in course of time it tends to involve the distal halves of all four limbs. Double club-foot is a common result, and there may be evidence of changes in the nerves. Moreover, the disease sometimes follows an attack of measles. Whether the primary flaw is in the muscles, or in the nervous system, or in both, is not yet known; but the disease marks a transition, from the point of view of classification, between the developmental defects of the muscular and those of the nervous system.

The motor path, or the path taken by the voluntary impulses passing from the brain cortex to the muscles, consists of at least two segments. The upper of these extends from the brain to the spinal cord, and the lower from the spinal cord, by way of the nerves, to the muscles. Premature decay sometimes occurs in one or other or both of these segments, but this is chiefly observed after full maturity has been reached. When the lower segment is involved, the condition is known as *chronic spinal muscular atrophy*, or *progressive muscular atrophy*. In rare cases, decay of this segment occurs in the developmental period, either in infancy or later, and sometimes in different members of a family. Similarly, decay of the upper segment, which is known clinically as *primary spastic paraplegia*, has also its analogue in cases which occur in early life and in several members of a family. Some cases of *cerebral* or *spastic diplegia* seem to be manifestations of a similar developmental flaw in the brain.

The disease known as *amaurotic family idiocy*, or *infantile cerebral degeneration*, may be described as a special variety of cerebral diplegia. So far as is known, it is almost confined to the Jewish race. It is frequently seen in several members of a family, it begins at about the age of three months, and it usually ends fatally within two years. Weakness begins in the muscles of the neck, and spreads over the trunk and limbs, which are at first flaccid but afterwards stiff. The muscular weakness is accompanied by mental deterioration, and optic atrophy and blindness also supervene. A distinctive feature of the disease is seen with the ophthalmoscope in the macular region, where there is a large greyish white area, with the cherry-red macula in its centre. The characteristic symptoms of this deadly disease are accounted for by the degeneration of neurons whose cells are situated in the cerebral cortex and retinæ, and whose axis-cylinders run in the pyramidal tracts and optic nerves.

Friedreich's disease or *hereditary ataxy* also begins in early life and runs in families. It is characterised by degeneration in the posterior and antero-lateral columns of the cord, and among the early symptoms are unsteadiness and weakness of the legs with loss of the knee-jerks. The weakness and inco-ordination gradually increase, and extend to the upper limbs. Later on, there are oscillating movements of the head and trunk when the patient sits up or tries to move. Defective articulation, nystagmus, club-foot and spinal curvature are other very important symptoms. Though the disease is incurable and progressive, it has but little tendency to cause death directly.

If now we turn to the region of the cranial nerves, we encounter *Leber's atrophy* or *hereditary optic atrophy*. This is a family disease which, like pseudo-hypertrophic paralysis, is apt to attack chiefly the males, though it is transmitted by the females.

In certain families, again, there may be *defect* or *poor development of the external ocular muscles*, in consequence, as is supposed, of a corresponding defect in the cells of the nuclei from which the nerves of these muscles take origin.

The essential element, then, in the various nervous diseases or degenerations to which I have referred, may be regarded as a premature decay of neurons, or nerve-cells with their processes, comparable to that which overtakes the muscle fibres in muscular dystrophy.

The tendency to attack several members of a family is displayed by other diseases of the eye than those connected with its nerves and muscles. *Retinitis pigmentosa* is a family disease associated with slowly progressive atrophy and pigmentation of the retinæ. The first symptom is inability to see well at night. The visual field shrinks in extent from the periphery inwards, until the patient may be unable to find his way about, though still perhaps able to read in a good light, or, at any rate, to see well in a straightforward direction. A considerable number of these patients are the offspring of consanguineous marriages. *Cataract* occurring in childhood and in families points to a similar defect of endurance in the lens.

Daltonism or *colour-blindness* and *albinism* may be mentioned as other diseases which show a tendency to appear in different generations of a family, or in different members of a family in one generation; but as these are not manifestly due to premature decay of tissues after birth, and are therefore not to be included in the category with which I have been dealing, they need not be further considered at this stage. The same remark applies to *congenital deafness* and to various *bodily deformities*, as well as to what has been described as "the most hereditary of all hereditary diseases," viz., the *hæmorrhagic diathesis*.

An excellent illustration of the class of disease I am speaking of is seen in that rare and curious malady *Xeroderma pigmentosa* or *Kaposi's disease*—excellent because, while a genuine family disease, it is almost never inherited. It confines itself, as a rule, to one generation in a family. While it attacks males and females with almost equal frequency, it commonly keeps to one sex in a particular family. Here the premature decay occurs in the skin, possibly, as Mr. Hutchinson suggests, under the influence of sunlight (as in the case of retinitis pigmentosa). In the first or second year of life, pigment-spots develop in the skin, exactly resembling freckles, both in their appearance and in their tendency to involve chiefly the uncovered parts. In the course of some months, or it may be years, dilated blood vessels become visible between the pigment-spots. Small, white, atrophic areas develop among the freckles on the face. Warts, many of them like the familiar flat, yellowish-brown, senile warts, also put in an appearance. Ulcerations take place, and lead to crust-formation and cicatricial deformity. Finally, tumours develop in the warts and ulcers, at first of a papillomatous, but ultimately of an epitheliomatous nature; and these multiple cancers naturally lead to a fatal issue unless they can be removed in time.

Among diseases of the skin which may be quoted as shewing both hereditary and family tendencies is *Ichthyosis* or *fish-skin disease*. This is characterised by great scaliness of the epidermis, and in exceptional instances the scales or plates are wart-like, and project so much that the patients have exhibited themselves at shows as "porcupine men." This was done by several members of the well-known Lambert family, in which the disease affected numerous males belonging to three or four generations.

Tylosis is another disease which exhibits the same two tendencies. It consists in a great overgrowth of the horny epidermis of the palms and soles. Ichthyosis and tylosis, however, can scarcely be regarded as illustrating premature decay of particular tissues; indeed, they are rather more allied to congenital malformations.

I may mention here, without further dwelling on the condition of *cystic kidneys*, which has been observed as a family affection; and also *Bright's disease*, which may shew either a family or a hereditary tendency, or both.

Nobody knows exactly what constitutes the carbohydrate-assimilating mechanism, but we know that in cases of *glycosuria* it is overtaxed, and that in diabetes this disablement is present to a serious

extent. In January, 1905, I had under my care a boy who was suffering from diabetes, and who recovered under treatment so that he became able to use a considerable amount of carbohydrate without glycosuria being induced. After he left the infirmary he relapsed, and he died about five months ago. He was one of five members (three brothers and two sisters) out of a family of twelve who had died from that disease, but no other relatives are known to have suffered. It would seem that in this particular family the carbohydrate-assimilating mechanism is liable to become worn out before the period of puberty is reached.

Glycosuria may of course be part of an inherited predisposition, as well as part of a family tendency.

Albuminuria of an innocent kind may occur in different members of a family. The most common variety is that which is known as orthostatic or postural. When the individual rises in the morning, the abrupt change to the upright posture so disturbs the circulation in the kidneys that they are unable for a time to prevent the escape of albumen with the urine. In normal individuals this does not happen; either the circulation accommodates itself more quickly to the change of blood-pressure which results from the change of posture, or the function of the glomerular epithelium is less disturbed by the change in the circulation.

Gout is a disease which is apparently due to a reduction in the capacity of the uric acid excreting mechanism in the kidneys; but this does not usually manifest itself before middle life. It shews both family and hereditary tendencies. It occurs mostly in males, and may, moreover, be transmitted by females who do not themselves suffer.

A rare and very interesting family peculiarity is the condition known as *spontaneous pentosuria*. Pentose is a sugar whose molecule contains five atoms of carbon, just as the glucose or dextrose of diabetic urine is a hexose containing six carbon atoms. These people regularly excrete pentose, even when their food contains none. The condition is evidently not a disease, but an anomaly of metabolism.

Cystinuria is another condition which may occur in families. Though it is rare, it is nevertheless important because it may give rise to urinary calculus, and thus compel some individuals to undergo repeated operations. Cystin is a normal intermediate product of proteid metabolism, and if given to normal individuals is all changed in the body. One theory of cystinuria is that it results from an anomaly of metabolism in the particular individual, but it has also been suggested that the cystin is due to an intestinal mycosis.

Alkaptonuria is perhaps as striking an example as any of an abnormal variety of proteid metabolism. The urine, when fresh, is highly acid and of normal colour; but it becomes darker on exposure, till it is reddish-brown, dark brown, or even black. Urine of this kind reduces Fehling's solution, but the fermentation, polarimetric, phenyl-hydrazin and bismuth tests are all negative. Alkaptonuria is harmless, and usually congenital and life-long. It is a family disease, but is rarely inherited. A large proportion of cases occur in children of parents who are full cousins, but who are not themselves affected. The peculiar characters of the urine are due to the presence of homogentisic acid, which is a normal intermediate product of the breaking down of proteid matter. Alkaptonuria may, like cystinuria, be looked upon in the light of what Garrod appropriately terms a "chemical sport."

Albinism is not so much an abnormal form, as a defect, of metabolism. It consists in the failure to produce pigments of the melanin group. It affects males more than females, is a family rather than a hereditary defect, and is sometimes met with in the children of first cousins.

In connection with anomalies of excretion and metabolism, it is appropriate to refer to anomalies of another important function—viz., muscular movement. Simple *tremor*, for instance, may be met with as a family and a hereditary affection, beginning it may be, at puberty, or later, and persisting throughout life. *Thomsen's disease* likewise possesses both family and hereditary tendencies. It has existed in the family of Thomsen, who is himself a sufferer, for at least five generations. Both sexes are liable, and the symptoms are usually first noted in childhood. The most characteristic feature is the tonic spasm of the muscles which occurs on first attempting to use them after a period of rest.

(*To be concluded in our next.*)

THE TUBERCULOUS AND THEIR HYGIENIC SURROUNDINGS AT HOME.

BY D. T. BARRY, M.D.R.U.I., D.P.H.

THE report of the Commissioners of National Education in Ireland for the year 1905-6 shows a most deplorable condition of school hygiene. The cramped space, lack of seats, and provisions for cleanliness, etc., form indeed a sorry picture. The scourge of tuberculosis which has ruined and is ruining the health of so many thousands of our stunted population, finds in such conditions a very potent form of sustenance.

However, I do not intend to deal with school hygiene in this contribution, which is merely a record of some personal observations of the sanitary conditions existing in the homes of tuberculous individuals in the south of Ireland. My excuse, if excuse be needed, for adding to the literature on the prevention of tuberculosis is that too much cannot be written or said anent this evil till a definite diminution in case incidence and case mortality occurs. We seem to get no nearer with time to a solution of the difficulty. Facts observed during our management of such cases, whether they point to success or failure, if systematically recorded would help materially to a better condition of things.

I shall give here a brief account of the actual conditions found in a few examples, with occasional reference to the general treatment adopted. Some of the cases came under my own care. Many others I was permitted to see through the courtesy and kindness of the medical men who had charge of them, and who have also allowed me to refer to them in this article.

CASE I.—J. K., a boy, æt. 5. Enlarged glands, felt in both lumbar regions, diarrhœa, night sweats, pallor, wasting, slight cough. A sample of sputum was obtained with difficulty, and examined for bacilli, which were not found. The house possessed two rooms, one of which was entirely occupied by an old invalid woman. The other room was used as kitchen and bedroom, accommodated three individuals, and exhibited the following: window, 18in. by 24in., could not be opened; large cumbersome covered-in bed which had remained unchanged in the same dark corner for many years; earthen floor with sundry tiny pools of water, one of which was located under the bed and overgrown with moulds. Plenty of good food was available, and the mother, by a little persuasion, carried out suggestions made. The window was with difficulty forced open, an improvised bed for the little patient was placed beside it, and he was regularly sponged. In a few months the cough and diarrhœa had ceased, and the appetite was improved.

CASE II.—D. M. This was an instance of pulmonary tuberculosis in a man of 24 years. A sample of sputum which I was permitted to take showed numerous T.B. The medical attendant had only recently been consulted, and had not so far an opportunity of examining the dwelling. This showed a very unsatisfactory state of things. He slept in a covered-in bed with a younger brother; the room was small, and its window was not made to open. The room was boarded, but presented numerous holes, patches of "dry rot," and musty odours. The subsequent history of the case I do not know

CASE III.—J. F., a boy of 12 years, who suffered from tuberculosis of the ankle-joint. He was a thin, pale, wasted youth, with poor appetite, cough, and sputum. No signs of phthisis were evident in the lungs, and no bacilli were found in the sputum. Here a small room, which had originally been boarded, but which at the time of observation presented a few bits of board in the form of "stepping-stones," served as sleeping-room for five people. What had been a window at one time was almost completely boarded up, and admitted very little light but no air. The boy was put in the kitchen, which possessed a window, to live. The joint was lightly scraped, and cleanliness enforced. In the course of two months the cough had disappeared, the appetite and general condition were better, and the joint was fast healing.

CASE IV.—J. C., a young man 23 years, one of a family of six, who inhabited a four-roomed house. He had been accustomed to sleep with a brother in a small, badly-ventilated room. The apex of the left lung showed signs of solidification; he had coughed up some blood, and had evening rise of temperature. The sputum showed many bacilli. A parlour was given over to him as bedroom, he was forbidden to sit in the kitchen at night, and cold sponging was adopted. In six weeks the cough was much improved, the bacilli did not seem quite so numerous, and the appetite was better. The physical signs were unchanged.

Of patients treated in sanatoria in Ireland I have practically no experience, but during nine or ten years of English practice I had to deal with a good many so treated in English institutions. It is the after treatment of such patients that concerns us here. They have been educated, so it is said, in hygienic principles, and they know the value of fresh air and cleanliness. In theory the majority of them do; in practice many do not. Their education soon yields to the exigencies of limited space and other inconveniences; the good habits inculcated gradually lapse, and the evil once more gets a hold. The most persistent supervision on the part of the medical attendant fails to keep some minds up to the scratch on these points, and yet we must depend on such supervision for ultimate success.

We shall always have tuberculous cases to treat in their own homes. They may have already been in a sanatorium, or they may be unable or unwilling to gain admission to one.

In most cases of early phthisis it is the custom of the patients to consult the doctor at the dispensary, or at his private residence, where good advice is always given, but not always followed. Those cases which are regularly attended at their homes are usually far advanced in the disease, and though sound hygienic principles which are enforced tend to check the spread of the mischief, it is usually too late for the patients to derive permanent benefit from them. In the early stages of the disease irreparable damage is done. While the doctor's advice may be fairly conscientiously followed in the matter of ventilation, of isolation, and of cleanliness, yet hitches occur. Baths are occasionally neglected, a little rain or wind provides a reason for shutting windows, and the attractions of the social circle in the hot, stuffy kitchen or parlour, prove too many for the invalid. Man is ever a gregarious animal.

The regular cleansing of the skin by sponge baths is a regular *bête noir*. Yet many practitioners who are sufficiently insistent succeed in enforcing this very useful form of treatment. It is cheap, and can be adopted in the very poorest cabins. It is only in few cases that the procuring of good food forms an insuperable difficulty. Such cases we cannot with any hope of success treat at home.

Honorary Fellowship of the R.C.P.J.

AT the annual meeting of the Royal College of Physicians of Ireland, held on St. Luke's Day, Dr. John W. F. Tatham was admitted to the Honorary Fellowship of the College, to which he had been previously elected. At the same meeting, Dr. Daniel J. O'Connor, Physician to the Mercy Hospital, Cork, was elected to the Fellowship, to which he was admitted on the 2nd inst.

THE SIMPLE EXTRACTION OF SENILE CATARACT BY TEALE'S METHOD.(a)

By CHARLES G. LEE, M.R.C.S.,
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IT may seem a somewhat uninteresting subject to many that I am about to bring briefly under your notice, but after all it is possibly as important to all of us to know by what method an opaque lens may be best removed as to learn which is the better route by which to reach a stone in the bladder, or how best to amputate a thigh. Whether these things are so or not, the question has been one of surprising interest to ophthalmic surgeons, from the time of De Beer right through the Von Graefe period to the present. Many expedients have been adapted to this end, but their enumeration would be beyond the limits of these notes.

One of the most important points to determine is: Shall an iridectomy form part of the operation for extraction, or shall the cataract be removed without cutting the iris? Von Graefe's incision being placed so far back made it almost imperative to cut off a portion of iris, otherwise a large prolapse and subsequent incarceration of iris would take place. The incision at present in vogue, "the three millimetre flap" of De Wecker, although not so far back, is placed at the periphery of the cornea, and is open to similar consequences. The excision of iris itself proves a complication in the technique, for the effusion of blood that necessarily takes place into the anterior chamber obscures the next step in the operation, viz., laceration of the lens capsule. Notwithstanding, there remains a goodly number of expert operators who still adhere to this complicated procedure.

On the other hand, many operators have escaped this difficulty by performing the iridectomy some days or weeks before the extraction. This method has much to recommend it; for, although it requires two sittings for its completion, it makes less demand on the patient's self-control, and enables the operator to see clearly what he is doing. It is a procedure much favoured by my valued colleague Mr. Richard Williams, and one that I have myself chiefly adopted for many years.

While this, and much more which might be said, is admitted, it remains that two operations, when one may suffice, doubles the risk from sepsis. The loss of an eye, following a preliminary iridectomy, which happened in my private practice last year, brought this danger so strongly before me that I determined to try if some other method might not serve equally as well in results, and without this grave possibility. Before this time I had on several occasions performed the simple operation for extraction, and had still more frequently seen Mr. Edgar Browne accomplish it with great brilliancy; yet, from time to time, one's own experience confirmed the words of that well-known Dublin oculist, C. H. Swanzy, who says, "The extraction without iridectomy exposes the eye to the serious danger of prolapse of the iris into the wound." This danger, then, always imminent, deterred me from the ordinary simple extraction.

Some twenty years ago I was privileged to observe the practice of Mr. Pridgin Teale in Leeds.

(a) Read before the Liverpool Medical Institute.

He was then extracting the lens without an iridectomy, and by means of an incision quite novel to me. Since that time I have been able to see Mr. Teale operate occasionally, and also Mr. R. N. Hartley, who adopts Mr. Teale's method. After each visit I have wished to emulate these gentlemen, but a prolonged practice of the combined method had conferred a certain amount of confidence, if not dexterity, in that method, so that I hestitated to forsake it.

The unfortunate occurrence to which I have already alluded determined me to attempt Mr. Teale's operation; and during last session I submitted for the inspection of this Society the first five persons on whom I had operated. To-night I give particulars of these, with three additional ones, making eight in all.

Before considering these cases, it will be well to indicate some features in which the operation differs from others, and what advantages its adoption appears likely to offer. All these things have been plainly set forth by its author in the Bowman Lecture for 1893, and may be read at large in volume xiii of the Ophthalmological Society's *Transactions*, from which record I shall extract such portions as may seem necessary to our better understanding.

There are two important characteristics—

1. The knife employed.
2. The site of the section.

On these two depend all the subsequent details.

The knife is one modified by Mr. R. N. Hartley, and very much resembles Taylor's cataract knife: it is much deeper in the heel than elsewhere in the blade; it is also thicker in this situation, more or less of a wedge; by virtue of this it retains the aqueous in its passage across the anterior chamber, and also lessens the tendency of the iris to double over the blade, advantages which the narrow knife of Graefe does not possess. The incision is situated altogether in the corneal structure; and, as this fact, added to the method of making the section, constitute indispensable

FIG. 1.

conditions of the operation, I cannot do better than quote the author's own description:—

"The point of the knife enters the cornea just within the outer margin at its equator, and emerges at a counter-puncture just within the inner margin of the cornea, at a level about two millimetres above the equator. As soon as the counter-puncture is well accomplished, and the point of the cataract knife has passed

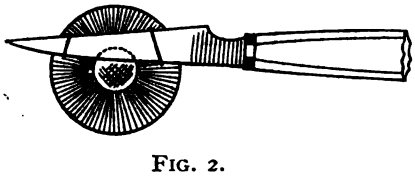

FIG. 2.

out of the cornea to the extent of about four millimetres, the next step is taken. This is the most critical part of the operation.

"The knife is somewhat rapidly and with a sort of knack turned directly forwards so that the blade, which up to this point has been parallel with the iris, comes to a right angle with the back of the cornea. The section is completed by cutting directly forwards, this final cutting being vertically through the corneal thickness, absolutely linear, and in position about midway between the horizonal equator and the upper margin of the cornea. The incision thus made is practically a shallow flap, chiefly linear, with a small limb at an obtuse angle, corresponding to the heel of the knife at the outer edge of the cornea, and a still smaller, hardly perceptible limb, corresponding to the point of the knife, at the inner edge of the cornea.

At the limbs the knife passes through the cornea obliquely, but in the horizontal linear part it cuts vertically through the corneal structure."

From a consideration of the section and its position, it will be seen how unlikely it is that the iris should be prolapsed; indeed, not much more than the edge of the iris is extruded at the time

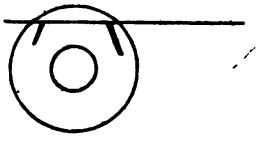

FIG. 3.

of the delivery of the lens, which is in marked contrast to what happens when the line of incision is laid at the circumference of the cornea. The edges of the wound, by reason of the incision being for the most part vertically through the cornea, fall into such accurate apposition that healing takes place rapidly, and there is no need for a conjunctival flap to prevent the ingress of bacteria.

It may seem that some difficulty might be experienced in acquiring this knack of turning the knife; and I may confess that this thought prevented me from attempting the operation years earlier, a fact which I much deplore. If we get, and maintain, the point of the knife well through the cornea, on no account withdrawing it as the turn is made, no difficulty will be experienced; and as neither conjunctiva nor iris has been wounded, the proceeding is absolutely bloodless, and therefore every step is clearly seen.

There remains little more to add. The eye had better not be disturbed for dressing, unless pain is complained of, for from three to eight days. In three of my patients the first dressing was done on the eighth day, and in none earlier than the third. Usually neither eserine nor atropine is required, nor is it imperative that the operator should be ambidextrous.

The visual results obtained in these eight cases are as follows:—

1 attained $\frac{6}{6}$
3 " $\frac{6}{9}$
1 " $\frac{6}{12}$
1 " $\frac{6}{18}$
1 patient too illiterate to responds to tests, but counted fingers length, opened, off some 30 feet.

In only one case did the operation call for any comment. In it, owing to the restlessness of the

patient, the iris was wounded when the point of the knife was crossing its surface, but the vision obtained was $\frac{6}{18}$; and as the other eye had been operated upon by the combined method, with $\frac{6}{60}$ as a result, the advantage rests with the simple extraction.

During the healing process one of the patients (Mary M.), the third night after operation, severely knocked her eye and re-opened the wound, causing an escape of aqueous enough to thoroughly damp the pads, which were changed, but no further mischief resulted, and the vision obtained is $\frac{6}{9}$.

Another patient's (Henry M.) eye was dressed for the first time on the eighth day; after the removal of the pads the eyelids were seen to be swollen, and when separated a free mucous discharge escaped: evidently he had a smart attack of catarrhal conjunctivitis. The incision was firmly healed, and cornea quite clear; his vision is $\frac{6}{9}$.

These two cases incidentally prove the value of Teale's incision; in other case we should have had in one prolapse of iris, and in the second probably suppuration of the wound.

I have made no attempt in these remarks to exhaust every argument that might be advanced in favour of this procedure; my wish has been to demonstrate that it is at once a simple and efficient method of operating in most cases of senile cataract; that its results, even when advanced by one not accustomed to the method, will bear comparison with those obtained by other and often more complicated ones; and that, although it is neither German nor American in its conception, it is well deserving of trial by all who desire to advance the art of ophthalmic surgery.

Tabular List of Cases.

Name.	Age.	Eye.	Date of Operation.	Visual Result.	Remarks.
Michael M'H.	70	Right	13 Oct. 1903	D D c̄+9⊃+2 cyl. axis vertical. V=$\frac{6}{9}$.	First dressing eighth day after operation.
John H.	65	Left	20 Oct. 1903	D c̄+9⊃+1.75 cyl. V=$\frac{6}{9}$.	First dressing eighth day after operation.
Mrs. M'A	56	Left	14 Nov. 1903	c̄+9⊃+2.50 cyl. V=$\frac{6}{9}$.	Patient knocked her eye violently during third night after operation; loss of aqueous, but no prolapse.
Mary E.	51	Right	12 Jan. 1904	c̄+11 3+2^{a} cyl. V=$\frac{6}{12}$.	No remarks.
Henry M.	67	Left	12 Jan. 1904	c+9 3+2^{a} cyl. V=$\frac{6}{9}$.	First dressing eighth day. When pads were removed, lids very swollen, profuse mucous discharge from between lids. Cornea quite clear. Wound healed.
Thos. A.	68	Right	13 March, 1904	c̄+10^{a}. V=$\frac{6}{18}$.	Iris pierced by knife in its passage across anterior chamber. Patient very restless.
Sarah H.	68	Right	15 Aug. 1904	Approximately say, $\frac{6}{18}$	Dressing eighth day. Some adhesions posterior. Patient both illiterate and unintelligent; could not respond to tests, but counted fingers reading at 6 metres.
Mrs. B.	78	Left	4 Oct. 1904	Sees time on watch.	Done so recently. January 1895. V–$\frac{6}{9}$.

CLINICAL RECORDS.

CASES OF DISEASED NASAL CAVITIES AND CASE OF EXTRA-DURAL ABSCESS WITH SEPTIC SINUS THROMBOSIS.

Under the care of J. GALBRAITH CONNAL, M.B., F.F.P.S.G.

Lecturer on Aural Surgery in Anderson's Medical College, Glasgow

CASE 1.—*Sphenoidal Sinusitis.*—Patient, man 36 years of age, who complained of nasal obstruction and discharge in right nostril of many years duration. He thought the trouble originated in an attack of measles when he was six years old. During school life he was troubled with greenish crusts coming down his nostrils and often into his throat. When the secretion of pus stopped he had severe pains, referred sometimes to the forehead, sometimes to the back of the ear, and sometimes to the neck. When the headaches were severe he became sick, and often felt dull and sleepy.

Examination showed in the right nostril that the pus had caked, and formed a crust over the middle turbinal. There was also pus noticed in the nasopharynx.

The middle turbinal was removed under cocaine anæsthesia, and the anterior wall of the sphenoidal sinus exposed, when pus was seen welling out of its ostium. The anterior wall of the sphenoidal sinus was broken down with Hajek's hooks. At the junction of the roof and back wall of the cavity an area of carious bone was detected with the probe. This was gently curetted. The opening speedily contracted, and caused a recurrence of his headaches, and for a second time a fairly large opening was punched out of the anterior wall.

The discharge is now less, and his headaches are greatly better.

CASE 2.—Patient operated on for combined empyemata of the maxillary antrum, the frontal, the ethmoidal and sphenoidal sinuses.

Came under observation with profuse purulent discharge, and feeling of obstruction in the left nostril. The middle turbinal was greatly hypertrophied, and it was removed. Pus was seen coming from all the accessory cavities on the left side.

CASE 3.—Patient from whose left nostril a large sarcomatous tumour was removed three and a-half years ago, in whom there has been no recurrence.

Man 59 years of age. Seen for the first time in February, 1903. The tumour extended from the anterior nares to the posterior choana. It probably originated at the posterior extremity of the turbinal and spread forward, becoming attached to the septum and to the floor of the nose. The tumour was removed at several sittings with the scissors and cold snare, the septal attachment being cut through with the electric cautery. After removal of the tumour the parts were thoroughly cauterised with the electric cautery. This was done three and a-half years ago, and there has been no recurrence. Sections of the tumour showed it to be spindle-celled sarcoma, with an admixture of round cells.

CASE 4.—Patient on whom the radical mastoid operation was performed for purulent otitis media. When seen for the first time patient had a primary diphtheria of the external auditory canal.

Boy, twelve years of age, with purulent otitis media, dating from infancy. The left ear had a perforation in the postero-superior segment of the tympanic membrane, with slightly offensive discharge. On the posterior wall, and partly on the floor of the external auditory canal, there was a whitish membrane. A part of the membrane was sent to the Corporation Bacteriological Department, and reported positive. Swabs from the nose, nasopharynx and pharynx were reported negative. Temperature was 101.2° F.; pulse, 120; urine normal, free from albumen.

After a period of several weeks the radical mastoid operation was performed for persistent pyrexia (Ambulatory enteric was excluded). A carious area

* Abstract of notes on patients shewn at Glasgow Medico-Chirurgical Society, on October 19th, 1906.

was found in the antrotympanic passage and floor of the antrum. After the mastoid operation his convalescence was retarded by a slight attack of subacute rheumatic fever (pains in the joints and temperature up to 103.8), which yielded to salicylate of sodium. The after-history was uneventful. Mastoid wound healed, and there is a dry cavity in the ear.

The points of interest in the case are the persistent pyrexia before operation and the primary diphtheria in the ear, which is very rare. Diphtheria in the ear, secondary to diphtheria of the nose, pharynx or nasopharynx, is not so rare, the infection taking place through the Eustachian tube to the middle ear.

CASE 5.—Case of purulent otitis media, with extradural abscess and septic sinus thrombosis.

Man 21 years of age, with purulent discharge in right ear of two years' duration; in left ear of six weeks duration. Severe pain in the left ear for past eight days; severe rigor the day before admission to hospital.

Left mastoid was opened. Foul-smelling pus was found between the tegmen and the dura. On working backwards pus was liberated over the sigmoid sinus. Three days later, after a severe rigor, the internal jugular vein was ligatured, and the lateral sinus split open and found to be filled with greyish clot.

The patient died some days after. The post-mortem showed effusion in both pleural cavities, multiple abscesses in the lungs, and purulent clot in the vein and in the lateral sinus.

OPERATING THEATRES.

GREAT NORTHERN HOSPITAL.

OPERATION FOR PERFORATED GASTRIC ULCER.—MR. PEYTON BEALE operated on a woman, æt. 25, who had been admitted with all the typical symptoms of perforated gastric ulcer. There was a previous history of some years' duration of gastric ulcer. The patient was suffering very severely from shock, but it was not thought that there was any hæmorrhage going on, and so it was assumed that the shock was alone due to the perforation, and the consequent escape of stomach contents into the peritoneal cavity. The patient was put to bed and surrounded with hot bottles. She was given strychnine and a little brandy, and in about two hours she was much less collapsed. An incision was then made in the left linea semilunaris, and on opening the peritoneum gas and some fluid escaped. A large quantity of hot, sterile water was poured in, the hand being introduced into the abdominal cavity in order to move the intestines about freely, and so to wash out the cavity. After this had been repeated three or four times, the stomach was drawn out through the wound and carefully examined. A thickened patch, surrounded by inflamed tissue, was felt about the middle of the lesser curvature. Whilst Mr. Beale was examining this to see if there were any perforation in it, the house surgeon, Mr. Clarke, found a circular aperture about a quarter of an inch in diameter about an inch and a half lower down in the lesser curvature. On further examination a great deal of thickening was felt at the back of the first part of the duodenum, giving rise to a suspicion that there was an ulcer there also. The edges of the circular aperture were pared with scissors, and the borders of the stomach muscle brought together with three or four silk sutures. External sutures were then passed through the peritoneal covering of the stomach so as to completely cover over the previous line of sutures. The peritoneum and abdominal wound were closed, with the exception of a small aperture through which a gauze drain was passed. The patient was then sent to bed, ordered to be kept very warm with hot bottles, and to have a hypodermic of morphia directly she began to regain consciousness. She was ordered to have hypodermics of morphia as often as might be necessary in order to keep her absolutely quiet—in fact, to keep her in a state just short of coma. Mr. Beale said that he considered the first thing to be done in all abdominal cases in which there was any severe shock, providing it were not due to hæmorrhage, was to get the patient thoroughly warm and to watch the pulse so that directly it began to regain strength, the operation might be performed. The operating table should be one capable of being warmed, and the patient's extremities should be kept wrapped up in cotton wool. No more anæsthetic should be given than was necessary to make the incision through the abdominal wall, and when this had been done the peritoneal cavity should be repeatedly washed out with hot sterile water or normal salt solution. As a rule, he pointed out, nurses in the theatre did not make the water hot enough. They prepared it at a temperature of about 107° F., but by the time it got to the peritoneal cavity it was rarely over 80° F. He therefore preferred the water so hot that one could only just bear the whole hand to be plunged into it. The effect of washing out a peritoneal cavity with such hot water was most remarkable, and exceedingly rapid. He did not believe in any attempt to completely wash out the cavity. With regard to sewing up the perforated ulcer, it was, he considered, of no use to put in a great number of stitches, as the coats of the stomach were so hard and œdematous that they would not bear many efficient sutures. He believed in a few sutures of thickish silk not passing through the mucous membrane; his view was that lymph was poured out along the line of sutures within a very few hours, and that this effectually prevented any leakage; the more stitches one put in the greater was the risk of their all cutting through. As regards the anæsthetic, the less administered the better; patients must have some during the incision through the abdominal wall, and also during the suturing of the same, but they need not have any in between. As regards after-treatment, he believed in absolute rest, such as could only be secured by morphia given every two hours. It was advisable, he thought, to administer hot nutrient enemata every eight hours during the first thirty-six hours after operation, but after that period he gave liquid food by the mouth. He had adopted this line of treatment during the last three years, and it was very noticeable how well very severe abdominal cases, particularly perforated gastric ulcers, progressed under it. There was another point, he said, worth considering in a busy hospital ward, namely that the patient, when continuously under morphia, made no noise and gave no trouble.

A fortnight after operation the patient is doing perfectly well, and has had no bad symptom of any sort.

CANCER HOSPITAL.

CARCINOMA OF THE BODY OF THE UTERUS.—VAGINAL HYSTERECTOMY.—Mr. BOWREMAN JESSETT operated on a woman, æt. 36, who had been admitted into the hospital suffering from menorrhagia. She thought she had had a miscarriage about three months ago, when she had experienced a considerable loss of blood, several clots coming away at the same time. She had since been suffering from dysmenorrhœa, losing small quantities of blood mixed from time to time with a slightly purulent discharge. She had some twelve

months ago had a good deal of pain, and was told she had retroversion of the uterus; for this she wore a ring for a year. She had also suffered a good deal from bearing-down pains since her last child five years ago. She was a stout, healthy-looking woman. Abdominal examination revealed nothing. *Per vaginam*, the body of the uterus was found to be enlarged, and there was considerable erosion of the os, a foul discharge coming from the cervical canal. The tissues of the os were soft and bled readily on examination. On passing a sound into the uterus, it passed for about three inches, causing a good deal of hæmorrhage. The uterus was mobile, and Mr. Jessett considered it a good case for vaginal hysterectomy. The patient was placed in the lithotomy position, and Sims' speculum passed; the cervix was seized with vulsellum forceps and drawn down between the vulvæ. The anterior fornix was opened up with scissors and the bladder separated with the finger. Douglas' pouch was freely opened through the posterior fornix. The lateral fornices were then divided up, and, the uterus having been dragged well down, the uterine arteries on each side were ligatured with linen thread. The tissues were next divided on the uterine side of the ligatures and separated from the uterus freely. The fundus was now seized with vulsellum forceps, and drawn down through the posterior fornix. The lateral ligaments were transfixed with double linen thread, and the ovarian arteries, round ligaments and Fallopian tubes firmly ligatured. The uterus was then cut away from its attachments and removed. The anterior and posterior margins of the peritoneum were next seized with forceps and drawn well down, and the vagina packed with iodoform gauze. Mr. Jessett said that this was a typical case in which, in his opinion, vaginal hysterectomy was called for in preference to removal of the uterus by the abdominal route. The uterus was freely mobile, and the disease was evidently of recent date, and restricted to the fundus uteri. By removing the uterus by the vaginal route patients, he pointed out, made a very much more rapid convalescence; besides, the abdominal walls were not in any sense weakened, and the chances of any recurrence were quite remote. Mr. Jessett stated he had had many cases in which he had employed this method that were alive and well, and free from any recurrence, the operations having taken place from four to twelve years ago. With regard to the performance of the operation, he said that the first principle was to select cases in which the uterus was mobile, as in those cases in which the disease had extended into the cellular and connective tissue around the cervix, affecting probably also the broad ligament, this operation was not to be recommended. In such cases he did not consider that any operation, either by the abdominal or the vaginal route, could be relied upon to remove the whole of the disease, and although operations as described by Wertheim were credited with being able to get wide of all diseased tissues, including the removal of the enlarged sacro-lumbar glands, yet he would be much afraid that within a comparatively short, in such cases, time the disease would manifest itself again.

The patient left the hospital convalescent three weeks after the operation.

THE Commissioner of Health for Chicago gives statistics of mortality from diphtheria before and after the introduction of the antitoxin treatment on Oct. 5th, 1895. In the ten preceding years 10,019 deaths were reported from diphtheria, an average of 9.87 per 1,000 of population. In the next decade there were 6,446 deaths from diphtheria, an average rate of 3.94 per 10,000. Had the previous rate obtained there would have been 9,701 more deaths.

TRANSACTIONS OF SOCIETIES.

LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD THURSDAY, OCTOBER 25TH, 1906.

The President, FRANK T. PAUL, F.R.C.S., in the Chair.

EXTROVERSION OF INTESTINAL MUCOUS MEMBRANE.

MR. G. P. NEWBOLT showed a patient in whom fæcal fistulæ complicating an attack of tubercular peritonitis had been cured by intestinal anastomosis. Extensive prolapse and extroversion of the mucous membrane of the small intestine, with profuse discharge of mucus now existed at the site of the old fistulæ.

Mr. R. W. MURRAY mentioned a similar case which had been under his care, in which he had successfully performed intestinal anastomosis; but the patient died 12 months later owing to an accumulation of intestinal secretion in a portion of the gut which had been completely occluded.

CÆSARIAN SECTION.

Dr. ARTHUR WALLACE read a note on Cæsarian Section, based on an experience of 16 cases, in 13 of which operation was indicated for pelvic deformity, and in 3 for obstruction by tumours. The former included four instances of the repeated operation. The maternal mortality was 6.25 per cent., the only death occurring in the case of a patient who was probably infected before admission to the hospital. The performance of every Cæsarian Section in such a way as to permit of future pregnancy was advocated.

Dr. H. BRIGGS alluded to the tedious management after Porro's operation in his earlier experience, and to the almost invariably easy recovery of the patient after Cæsarian Section in his recent practice. In one patient, whose pelvis was contracted after tubercular sacro-iliac disease, there was only an enfeebled constitution to account for the fatal shock nine hours after a smooth and uncomplicated operation in a well-equipped public hospital. In private practice he had successfully operated in three cases, and he thought it was well to appreciate beforehand the inconvenience and dangers—unexpected labour, a midnight operation, distance of locality, and lack of equipment. He preferred a clean, healthy peritoneum to utero-parietal adhesions, which were apt to be imperfectly maintained, and, if complete enough for a future Cæsarian operation, they would rarely be an unmixed advantage.

CHARCOT'S JOINT DISEASE.

Dr. T. R. BRADSHAW showed a man, æt. 37, with Charcot's disease of the ankle. The joint was disorganised, the astragalus being dislocated forwards, and the malleoli much enlarged. The condition had existed over three years, but the patient was still able to use the limb. The patient had tabes dorsalis in the pre-ataxic stage, evidenced by lightning pains, myosis, Argyll-Robertson pupils, absence of knee-jerk, and a rapid pulse. There was good reason to suspect antecedent syphilis.

GASTRIC ULCER AND DYSPEPSIA.

Dr. J. HILL ABRAM read a paper on gastric ulcer and dyspepsia. The first section of the paper dealt with the difficulties of diagnosis of ulcer, stress being laid upon failing nutrition, localised pain and tenderness, especially the "douleur en broche." Hæmatemesis could not be regarded as a decisive symptom, and cases were quoted in support of this statement in which the stomach had been examined directly. Dr. Abram suggested that the diagnosis of ulcer was made too readily by physicans, and that the strong surgical statements of recent years were due to this fact. In support of this position he quoted several sets of figures, and showed from the Liverpool Royal Infirmary reports (1896-1905) that in the medical wards out of 293 cases only 14 were males; whilst in the surgical wards out of 134 cases, 43 were males. Further, that the mortality rate in the medical wards was 4.8 per cent., whilst in the surgical wards it was 26 per cent. He then discussed the question of hæmatemesis, and stated that he had not seen a fatal case of hæmate-

mesis in simple chronic stomach patients, and also his belief that medical treatment was sufficient. Dr. Abram criticised the statement that chronic dyspepsia was, in a majority of instances, due to mechanical interference with the stomach, the result of old ulceration. In four years 127 cases of chronic stomach trouble, cancer, congestion, and the dyspepsia of tuberculosis being excluded, had passed through his wards at the Royal Infirmary. In 35 only could he admit that the symptoms or the course of the disease and the results of treatment justified a diagnosis of ulcer or its results; 13 of these had to be transferred to his surgical colleagues. In *true cases of gastric ulcer* the modern surgical position was probably sound. The common causes of chronic dyspepsia were, in his opinion, first and foremost constipation, and second neurasthenia. Dr. Abram offered proof of the mode of action of constipation, holding it to be reflex and not auto-intoxication. Finally, he emphasised the risk of classing cases of neurasthenia as examples of dilated stomach, and said that in such cases operation would do but little credit to surgery.

Dr. T. BRADSHAW said that arbitrary rules founded on the situation and character of the pain could not be implicitly relied on. In practice one treated this class of case by rest and dieting, when they almost always recovered for a time. If, as often happened, successive relapses occurred on returning to ordinary diet and mode of life, one felt bound to offer the chance of benefit from surgical interference. In a certain proportion of cases thus dealt with no benefit would result; but it was not always possible to tell before operation which were the cases not amenable to it. In this, as in other matters, experience was the guide of life, and as Sir W. Gowers had said in another connection, in order that we should be right in 19 cases, we must be content to be wrong in the twentieth. For his own part, he had always seen greater benefit from operation in gastric ulcer, and where there was no benefit he could not remember any case where the operation had made the patient worse than before.

Dr. C. J. MACALISTER thought that there should be joint action between the physician and surgeon in cases of doubt, but did not consider that hæmatemesis warranted the case being turned over to the surgeon, because the symptom did not always indicate ulceration. In the case with a history of hæmatemesis, and in which the patient had been suddenly seized with violent pain in the stomach region, giving rise to a suspicion of perforation, on opening the abdomen tubercular peritonitis and not gastric ulcer was found. Dr. Macalister related a case showing that appendicitis and gastric ulcer might occur together in the same patient without any interdependence. Constipation was not always a cause of dyspepsia; he had had many cases of severe constipation under his care in which there were no symptoms of dyspepsia. Constipation was in all probability in many cases of chronic dyspepsia an effect and not a cause. A healthy stomach meant healthy action of the intestinal glands.

The following members also discussed the paper:—Mr. G. G. Hamilton, Mr. Rushton Parker, Dr. R. J. M. Buchan, Dr. A. G. Gullan, Dr. J. Lloyd Roberts; and Dr. Abram replied.

NORTH-EAST LONDON CLINICAL SOCIETY.

MEETING HELD THURSDAY, NOVEMBER 1ST, 1906.

The President, Dr. A. E. GILES, in the Chair.

THE following cases and specimens were exhibited:

Dr. F. J. TRESILIAN (Enfield) read notes of a case of Pernicious Anæmia in a man in whom the chief symptoms were an intense anæmia, œdema of the legs, and great weakness. He had improved considerably under arsenic. Blood-films were shown revealing the presence of numerous poikilocytes.

Dr. A. J. WHITING showed three cases of Tabes Dorsalis in men exhibiting various symptoms or phases of the disease. One patient was practically blind from optic atrophy and yet had little or no ataxia.

Dr. G. P. CHAPPEL showed a man, æt. 49, with Dilatation of the Stomach and Severe Vomiting. He had been losing weight, and there was a small tumour to be felt beneath the right rectus muscle. He was admitted into the Tottenham Hospital, and the stomach was systematically washed out. Lactic acid was absent from the gastric contents, but free hydrochloric acid was present, together with sarcinæ. This analysis led the exhibitor to incline towards the view that the condition was one of fibrous induration around an old peptic ulcer.

Mr. WALTER EDMUNDS showed a girl, æt. 14, with Tuberculous Glands in the Neck, which had been treated by the X-rays. There was now hardly anything to be felt, whereas six months ago there were large masses in both anterior triangles. There was a marked family history of tuberculosis, and the child's brother had been operated upon for a similar condition. The exhibitor stated that the main action of the X-rays was to produce a local fibrosis which gradually caused the tuberculous focus to absorb.

Mr. HERBERT W. CARSON showed a specimen of an Extra-Uterine Fœtation which he had removed from a patient, æt. 34. She was almost *in extremis* when admitted to the hospital, the temperature being 101°. At the operation the ruptured tube was found to be adherent to a portion of the small intestine, and, *apropos* of this fact, the operator called attention to recent findings which seemed to indicate that septic organisms played an important part in this class of case. He thought that the presence of the staphylococcus albus, which had been found in quite a number of cases, might help to explain the slight post-operative rises of temperature which frequently occurred in them.

The PRESIDENT exhibited (1) a specimen of Carcinoma of the Body of the Uterus; and (2) one of a Solid Ovarian Tumour.

THERAPEUTICAL SOCIETY.

AT the meeting in the Apothecaries' Hall on October 30th, Dr. T. E. BURTON BROWN, C.I.E., who succeeds SIR LAUDER BRUNTON, Bart., as President of the Society, occupied the chair.

The following papers were read:—

"Some further researches upon the Active Principles of Viola Odorata," by Mr. H. Whippell Gadd, F.I.C., which appeared in our last week's issue; and "The Therapeutical uses of Preparations of Viola Odorata," by Dr. W. A. Potts.

Mr. GADD had carried out many new chemical tests, in the endeavour to demonstrate the presence in violet leaves of the glucoside viola-quercitrin, described by Professor Mandelin. He was sorry to report that his results were entirely negative. He had previously sought in vain for an alkaloid in violet leaves; and now he had searched in vain for a glucoside. He had found varying quantities of glucose in different samples, but could not confirm the presence of viola-quercitrin. The active principle was still quite unknown.

Dr. POTTS showed tracings of the effects of violet preparations upon the pulse, the blood-pressure, and frog's heart. He found very definite depressor effects upon all parts of the circulation; it would therefore be unwise to administer the drug in cases of feeble cardiac power. The action was transient but definite. He had tried the violet preparations both upon himself and upon patients. He found that, after administration by the mouth, the subsequent urine resisted decomposition for many days even in hot weather. He thought this indicated an antiseptic action of some product of the violet preparations in the secretions. This perhaps accounted for the undoubted mitigation of the foulness of discharges from cancers, &c., after the use of the drug. He had also found great relief to pain by local application of violet fomentations, when other means failed. His conclusions were, that violet preparations were most useful (1) locally, for the relief of pain; (2) by the mouth or hypodermically,

for the relief of foul discharges from ulcerating growths; (3) that it was unwise to use them in cases of failing heart.

Dr. Parker Douglas agreed that violet-leaf preparations were of great use in cases which were beyond surgical treatment. They mitigated pain and foulness of discharge, but were not curative.

Dr. Soper, Dr. Crichton, and Dr. Auld joined in the discussion.

Sir Lauder Brunton said he had found violet preparations of great use in the relief of pain and discharge; he said that Dr. Potts' experimental work showed results similar to those obtained with various saponins. The latter had been described by Liebrecht as "anæstheticæ dolcrosæ," in that they produced transient irritation of the skin, followed by anæsthesia. This suggested that violet preparations might be of the greatest use in the treatment of some affections of the eye. He hoped that Mr. Gadd would carry out more researches with the view of testing for saponins in violet leaves. The two papers suggested several lines upon which further experiments might now be undertaken.

Mr. Gadd and Dr. Potts replied. The latter said that violet preparations were being used at one ophthalmic hospital already; but with what results he was not yet able to say.

CENTRAL MIDWIVES BOARD.

Meeting held November 1st, 1906.

The President, Dr. Champneys, in the Chair.

A letter was read by the Secretary from the Clerk of the Denbighshire County Council, forwarding a copy of a resolution passed by the Local Supervising Authority for the County, urging the Board to issue a Welsh translation of the Rules and Forms. The matter was referred to the Standing Committee.

A letter was read also from the Clerk of the London County Council, reporting on the conduct of two certified midwives, to whom the Board expressed satisfaction, and from

Dr. W. H. B. Brook, resigning his position as a recognised teacher under the Rules of the Board. Although he hoped to be able to get together a large class, in all he had had only three applications.

The President regretted that such a good man should resign, and a resolution was passed to ask him to reconsider his decision and to withdraw his application.

The petition to the Board, signed by twelve medical men of Richmond, including the Medical Officer of Health for the town, to reinstate Mrs. Sellwood, L.O.S., was referred to the Standing Committee, as well as a matter dealing with the circulation of circulars by a certified midwife.

THE PROPOSED SECOND STANDARD OF TRAINING.

The Secretary read to the Board a letter from the Secretary of the Queen Victoria's Jubilee Institute for Nurses, embodying a resolution passed by their Council on October 31st, 1906, to the effect that great difficulties would be raised in the working of the Institute by withdrawing the training and supervision of midwives from the Central Midwives Board, that the amendments of the Privy Council suggested, because a large number of the Queen's nurses are drawn from women trained in Poor Law Infirmaries, who hold the Central Midwives' Board certificate, so that the standard of training given in these infirmaries is one that nearly concerns the Institute. Under the proposed amendments, a second standard of training would be established for candidates from Poor Law Infirmaries, and the Board's certificate for such candidates would lose its greatest value. Consequently the employment of these women by the Institute would be limited, entailing thereby an unnecessary hardship on a very desirable class of women. The Council hoped that the Central Midwives Board would not adopt amendments creating a second standard of training.

The President moved that note should be taken of their valuable communication, which was carried unanimously.

The Secretary next drew the attention of the Board to its financial state, and pointed out that the roll had not yet paid its way. The discussion on this subject was adjourned to the next meeting.

The adjourned consideration of recommendation of the Standing Committee, that Local Supervising Authorities, having appointed Inspectors of Midwives, be requested to furnish the Board with copies of the rules that have been drawn up for the Inspectors' guidance, and that where no rules have been compiled, the Local Supervising Authority be asked whether such rules, if drawn up by the Central Midwives' Board, would be acceptable. Owing to the absence of Mr. Fordham, the consideration was adjourned.

The Standing Committee recommended that Dr. J. R. Kaye, County Medical Officer of the West Riding, and Dr. H. Handford, County Medical Officer for Notts, should be thanked for their letters, and assured they should receive the full consideration of the Board. These motions were carried.

The President moved, and Mr. Ward Cousins seconded, a resolution that a copy of the revised rules be sent to Dr. F. J. Smith, Hon. Sec. Metropolitan Counties Branch British Medical Association, and that he be informed that if he will specify in writing any further amendments which the Metropolitan Counties Branch may deem necessary, they will receive the consideration of the Board.

Dr. Parker Young's amendment, that if, after reading the report, Dr. Smith should require further information, the Board will be very pleased to hear from him, was put to the vote and carried.

The President moved, and Miss Paget seconded, the resolution that the application for approval as teacher of Arthur Thompson, M.R.C.S., L.R.C.P., should be granted for the purposes of the December Examination only.

Dr. Parker Young moved, and Sir William Sinclair seconded, in the absence of Mr. Fordham, "that where an application is made by or on behalf of a midwife whose case has been definitely dealt with after citation and a hearing by the Board, for the reconsideration of such case, the Secretary do inform the applicant that the Board are not prepared to re-open cases in which they have given formal judgment, and refer the applicant to the Rules.

Other business dealt with was the subject of examiners. Owing to the death of one of the examiners (Dr. Bell) just before the examination, considerable difficulty was experienced in finding a substitute, and Dr. Lyal, of Newcastle, filled the vacant post.

The Secretary pointed out that three more examiners were needed, one to replace Dr. Bell, and two others to examine the ever-increasing number of students; last week there were 270 candidates.

The President was of opinion that these were posts for rising men, who often were very patient and of much judgment, though it was still too early to advertise yet.

The business concluded with the fixation of the date of the next meeting of the Board for Thursday, November 29th.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Nov. 4th, 1906.

THE SURGICAL CONGRESS.

The Surgical Congress, which was held last month at the Paris Faculty, was very well attended. Not only did the questions present particular interest in the *ensemble*, but the communications of Dr. Doyen on his anti-cancer treatment, which last year excited so much unfavourable discussion, were awaited with eagerness, and have already been published.

One of the most interesting papers read was that by Dr. Calot, of Berck-sur-Mer, on the

TREATMENT OF CONGENITAL LUXATION OF THE HIP, AND WHITE SWELLING OF THE KNEE.

The most ardent partisans of the incurability of congenital luxation were obliged to admit themselves vanquished. The method of Calot has been put to the test, and the distinguished surgeon has succeeded in restoring good sound limbs, without shortening or claudication, to children to whom had been applied all kinds of apparatus, and on whom was attempted reduction of the luxation without success.

The details of the treatment have been published in book form by Dr. Calot, which can be had through any medical publisher.

White swelling of the knee was also treated in the Congress by Dr. Calot. He protested with great energy against those operators who cut and fired at will tuberculous joints. Not only did the lesion not get well, but the traumatic interference favoured the absorption of the toxines and the microbes by the blood, which carried the infection. Frequently after the operation the malady broke out further up, or the patient was carried off by meningitis. According to M. Calot, the white swelling got well if the patient lived at the seaside or in the country, if it is not opened or if it is not allowed to open spontaneously.

It gets well leaving the limb in a fair position, but frequently with limited movements.

The treatment consists essentially in modifying injections into the articular cavity, of which the best are composed of a solution of creosote and iodoform in oil. Under their influence the fungosities are softened, become liquid, and can be removed by tapping. Other solutions might be employed, as camphor and guaiacol, salol or thymol; but M. Calot gives the preference to camphorated naphthol, employed in doses of from 2 to 40 drops, according to the age of the subject, injected daily.

When the lesion is in a fair way of healing, the proper function of the limb should be considered. To this end the joint is fixed in plaster apparatus for six months, after which rest of the articulation should be enjoined for another period of six months, and finally massage and passive movement should be prescribed. By these means, the tumour will get well with a normal limb in the majority of cases if treated early; in the others, if the cure is only obtained by a stiff joint, it will be at least in a good position, solid and capable of rendering almost normal service.

M. Delagénière spoke on the

LIGATURE OF THE LARGE VEINS.

He ligatured with success the internal jugular, the axillary, and the femoral veins. M. Duret had practised a large number of sutures of veins successfully. M. Faure thought that it was often better to make a ligature than a suture, which prolonged unnecessarily the operation. Moreover, he had seen air enter the veins in seven or eight cases—once that accident threatened seriously the life of the patient. M. Depage (Brussels) had witnessed the same accident several times, but did not consider it particularly dangerous even when comparatively large quantities of air had penetrated; the alarming symptoms always yielded to artificial respiration.

TREATMENT OF LEUCÆMIA.

IF the different varieties of leucæmia are clinically well known, the cause of the malady is not, consequently there does not exist a rational or specific treatment of leucæmia. However, considerable improvement can be obtained by certain therapeutic agents, which might be divided into three groups—medicines, X-rays, and surgery.

The surgical treatment can only be extended to the extirpation of the hypertrophied glands when they threaten asphyxia by compression of the larynx, or the recurrent nerves.

Splenectomy gave but disastrous results where it was performed.

The best medical agent is arsenic, given in large doses and for a long time. Four or five drops of Fowler's solution should be given the first day, and increased by one drop daily to forty or fifty drops if the patient shows no sign of intolerance.

The employment of the X-rays has given even better results than the arsenical treatment, and may be applied without leaving off the arsenic. They have a destructive effect on the leucocytes.

Radiotherapy is indicated in all the varieties of leucæmia, and, as Belot said at the recent Congress held at Lyons, "a doctor who deprives a patient suffering from leucæmia of this treatment commits a fault as grave as he who does not give mercury for syphilis."

However, it must be said that success is far from being constant.

Acute leucæmia is not modified by radiotherapy, consequently it is only in the chronic form that hope of success can be entertained, and here again a distinction must be made between the rapid form of chronic leucæmia and the slow form, this latter being much more amenable to the treatment.

The rays should be directed on the splenic region, as the spleen is always greatly hypertrophied. One séance a week of a quarter of an hour's duration is considered sufficient, continued for an indefinite period, but with frequent interruptions

Long and important remissions have been obtained by this method, but no absolute cure has been recorded; the fatal termination is alone retarded.

STRUMOUS ADENITIS.

Chloride of Barium, 45 grs.
Cherry laurel water } ad. drs. ijss.
Distilled water }

Ten to twelve drops a day.

HYPNOTIC SUPPOSITORY FOR A CHILD.

Trional, v grs.
Paraldehyde, vj drops.
Cacao Butter, drs. ss.

GERMANY.

Berlin, Nov. 4th, 1906

AT the Society for Innere Medizin, Herr Kraus spoke on

GOITRE HEART.

He first discussed the cardiopathies caused by struma and certain affections of the thyroid dependent on disturbances of circulation. Goitre cardiaque was an open question. Stasis goître was of greater significance, which was caused by blocking of the superior vena cava by an ordinary goître. A venous vascular struma might result with a venous pulse, which experience showed gave rise to thyroidism. Blum's experiments justified the whole general opinion that venous disturbances in goitres were factors setting up cardiac affections. According to Kocher's experience, this thyroidism disappeared after operations; by this not only was the disturbance removed but thyroid tissue as well. As regarded the relation, between diseased thyroids and arterio-sclerosis, little could be said with certainty. The most important practically of the cardiopathics caused by diseased thyroid were the mechanical ones; less important those caused by disturbed venous circulation. The dyspnœic goitre heart especially frequently ran its course as a pure progressive cardiopathy, even when certain symptoms of hyperthyriosis (tremor and psychical excitability) were added. This form was very frequent, and called urgently for operation. Cardiac disturbance caused by pressure of the goitre on nerves that influenced the heart had been rarely proved, although several such cases were recorded in literature. This made it desirable to be in possession of diagnostic points for goître thyroidism in distinction from goître cardiopathies. Everything was still very uncertain. Cardiovascular disturbances caused by abnormal functioh of the thyroid were of the greatest interest both theoretically and practically when set up through the medium of nerves regulating the heart, and in the absence of mechanical factors (thyriogenic cardiopathies in the narrower sense). The speaker next

discussed the experimental clinical material at hand for possible thyroid cardiopathies. In any case, cardiac disturbance was here neither the cardinal symptom, nor even a special one. That hypothyroid diseases certainly did not affect the heart was important in an excluding sense for the pathogenesis of Basedow's disease. The symptomatology, statistics, &c., of thyrotoxic goître heart in this sense were discussed at length. For its "Selbständigkeit," a number of reasons were adduced, above all its character as a progressive cardiac disease in which the nervous, trophic, and other symptoms of thyroidism remained rudimentary. The causes for this one-sided, stationary, mitigated condition of the thyrotoxic syndrome in contrast to the typical Basedow type lay in part most probably outside the thyroid.

Herr Senator expressed himself as pleased that Kraus took up the position that the theory that for the origination of Basedow's disease the chief factor was the thyroid gland was not tenable; that something else of importance played a part—the sympathetic. In favour of this view was the fact that Basedow's disease was met with without any enlargement of the thyroid; in any case the enlargement frequently stood in no relation to the severity or mildness of the disease. Some questions still awaited an answer, as whether concomitants of Basedow were present in primary goître, such as diarrhœa or alimentary glycosuria.

Herr Benghardt had directed his attention to the latter point, and had "almost never" observed alimentary glycosuria and diarrhœa in goître heart. Sometimes Basedow and myxœdema symptoms were found together. One patient improved by serum treatment; later symptoms of myxœdema appeared; the earlier cardiac dilatation disappeared; in place of tachycardia there was bradycardia. Improvement had now been achieved by iodothyrine.

LUMBAR PUNCTURE IN ECLAMPSIA.

This subject is treated in a paper in the *Chl. f. Gynæk.*, Oct. 31, 1906, by Dr. E. Pollak. Thiess found the subarachnoid pressure increased. The writer sought to ascertain whether this raised pressure maintained for any considerable length of time had a deleterious effect on the sensitive nerve cells. He found degeneration within the cell bodies to the highest degree of degenerative changetogether with degenerative chromatolysis. Large and numerous vacuoles were visible. An unusually instructive case showed the gravest chromatolysis in the motor cells at the height of the fifth cervical segment. The nuclei also of the oculo motor nerves of the motor trigeminus of the hypoglossal showed changes. He described three cases which were noticeable, as in epilepsy death usually took place through œdema of the lungs, whilst in these it did not. They were cases in which, if the fatal result was not attributable to the puncture, as during the operation no change in the pulse or respiration was observed, yet death did take place if an exacerbation of the symptoms followed the puncture. He was of opinion that the bad result could not be laid to the operation. He thought that the shallow respiration and its gradual standstill were not an immediate result of the puncture, but that the lowered pressure following it did not efface the deleterious effects of the previously raised pressure. Theiss had also described three similar cases.

ABORTION PER RECTUM: RECOVERY.

K. Martin describes such a case in the *Münch. Med. Wochensch.* Oct. 19, 1906. He was called to a woman who had been suffering severe abdominal pain for a week. The uterus was enlarged in correspondence with a five months' pregnancy. To the right a doughy-feeling tumour was felt, and a diagnosis made of inflammation of the cæcum. Ten days after, the patient was found to be very pale, the pulse rapid, the temperature subnormal. Rupture of intestine was suspected. On the following day dark blood was passed per rectum. The pain and feeling of pressure increased, and after several enemata had been given an evacuation took place, consisting of a five months' fœtus, the umbilical cord and placenta. The case was one, therefore, of right-sided abdominal gestation that suppurated and emptied itself through the rectum.

AUSTRIA.

Vienna, Nov. 4th, 1906.

GESELLSCHAFT DER AERZTE.

THE session of this Institute was opened by the President Chrobak offering his greetings to the members, but regretting that so many deaths had occurred since the Institution closed for the summer holidays: in all ten, five honorary and five ordinary. Of the former, Prof. Brouardel, Franz Roser, Tomaselli, Vierordt, and Hermann Cohn; the latter, Profs. Neumann, Czermak, Weinlechner, Modry, and Murmann. The President reminded the members that one of their honorary colleagues would soon reach his seventy-fifth birthday, fifty of which have been spent in the doctorate. He also reminded them of the unveiling of the statue of Semmelweis in Buda-Pesth, a name which will go down to posterity.

The Danish report of the Cancer Committee was now opened to the members in a brochure entitled "Principiis Obsta."

HYDROCEPHALUS.

Hochsinger showed a child, æt. 9 months, with an enormous hydrocephalus, associated with spina bifida in the lumbo-sacral region. There were also manifestations of condylomata in the genito-anal region. According to the history of the parents, the child was born with a normal-sized head, but shortly after birth was affected with coryza with hæmorrhagic discharge which lasted six weeks. About the third week an idiopathic swelling commenced over the sacrum which soon burst and discharged a watery fluid, closing again about the third month. From this date the mother assures us that the head began to swell, but more rapidly the last two months. In the lumbo-sacral region a round fungoid tumour about 5 cms. in diameter still exists. In the labia majora and around the anus as well as the upper part of the thigh are to be found condylomata. The child exhibits symptoms of paralysis and rapid contractions usually associated with hydrocephalus. Hochsinger concluded that the hydrocephalus in this case was due to genuine syphilis producing specific ependymitis, and meningitis serosa, although a myelocystocele might be present. If the former the spina bifida might be assumed to be an hereditary syphilitic development of the whole disturbance.

Zappert thought the water was not due to syphilis, as it is well known that spina bifida when suddenly closed or healed up produces an increase in the cephalic region. No other symptom than condylomata ad anum is present to support the theory of syphilis, which is always present in spina bifida along with the sphincter paralysis and cutaneous anæsthesia. The congestion and thickening of the skin around the anal orifice often produce this imitation of condylomata.

Knopfelmacher said he confirmed Zappert's opinion, as he had a child with an equally large hydrocephalic head under treatment. He had twice performed lumbar puncture, and had relieved the hydrocephalus, which had previously all the symptoms that Hochsinger had demonstrated. By a repetition of the operation the head is diminished to within 1 cm. of its normal size.

TREATMENT OF EPILEPSY.

Redlich gave a *résumé* of a treatment that he recommended in epilepsy, which first of all is diet; and this should be vegetable as far as possible with milk, eggs, butter, and fruit. The food should be free from salt and spices, while all extracts of beef should be avoided, bread containing salts of bromide, which is now sold under the name of "Bromopan," is to be recommended. The medicine should consist of large doses of the bromides daily.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

THE GENERAL MEDICAL COUNCIL ELECTION.—Dr. Norman Walker opened his election campaign as a candidate for the post of Direct Representative by addressing a meeting in Edinburgh on November 1st. He pointed out that the primary duties of the Council were educational, and on that ground mainly appealed for support. It was easy to sketch the ideal scheme of medical education—easy to say that an Arts degree must be a precursor to medical studies, which might be extended for another year. But they must distinguish between the ideal and the practical. His ideal of a medical education was somewhat on these lines. He would demand a wider preliminary education than at present, and would give a certain elasticity to it, so that it should lead up to a degree either in Arts or Science. Practically, however, they had to deal with the five years' curriculum, and he was convinced that four of these must be devoted to medicine, and that the student should be compelled to pass his first professional before attending any of the classes in the medical curriculum proper. The preliminary examination might very well be stiffened. Five years ago he refused to commit himself to the one portal system, but since then he had become converted, and was now convinced that nothing but good could come of it. The interests of the public, as well as of the profession, required that they should press for legislation concerning patent medicines, requiring that each of these should have its composition printed on the label. He disagreed with those who said that club practice was iniquitous. He asked their support, because he believed his views represented those of the great majority of practitioners in Scotland as to what the duties, responsibilities, and privileges of the profession should be. The meeting was presided over by Dr. G. A. Gibson, and a motion was unanimously adopted welcoming Dr. Walker's candidature. Dr. Frost thereafter read a letter signed by 100 practitioners in Edinburgh favouring Dr. Walker's candidature. In further pursuit of his canvas Dr. Walker will address meetings on November 8th in Aberdeen, and on November 9th in Dundee. Voting papers for the election will be issued on November 24th, and the voting will be completed by December 7th. Dr. Walker contested the seat in 1901, and obtained 854 votes against 975 given to Dr. Bruce, the present representative.

SIR DYCE DUCKWORTH AT THE ROYAL MEDICAL SOCIETY.—The inaugural address of the 170th Session of this Society was given by Sir Dyce Duckworth, who chose as his theme "The Dignity of Medicine." After recalling his connection with the Society in his early days, he said that some educationalists held that the medical curriculum alone afforded a liberal education. From this view he dissented, maintaining that a preliminary study of the humanities was essential to all who aspired to a high place in the medical profession. He was convinced from long experience of the general superiority of those medical students who had enjoyed a good preliminary literary and classical education. No kind of scientific study could in itself supply the place of the Universities, or equally well train the mind. Coming to the topic of his address, he wished to treat of the dignity of the profession of medicine as a whole, as evidenced by its beneficent work as a social power in the community. This particular dignity seemed to him to have declined in recent years, and it rested with them to recover and reconstitute it. The value and benefits of medicine were not adequately recognised by successive British Governments or by municipalities. The timorous, stingy, and inadequate provision made for measures of public health, for the care of the insane, for research, and for sanitation generally, all bore witness to a mistrust of the high aims of medicine, and an indifference to the labours of the profession. How little the public recognised its duty was shown by the fact that it contributed nothing directly, and very little indirectly, towards the maintenance and equipment of any medical school in Great Britain, but was content to leave these bodies to support themselves, and their teachers to forego their emoluments to keep them in a state of efficiency. Everywhere else in Europe their claims were recognised by grants of public money in acknowledgment of the debt due to the beneficence of medicine. The same disregard was shown by municipal authorities in their extortion of rates from hospitals for the suffering poor. Discussions of medical subjects in the public press, so far from enlisting sympathy from intelligent laymen, rather tended to strain the relations between patient and doctor by inducing a captious mood which was apt to hamper successful treatment. The relations of patients to doctors were less satisfactory than formerly; confidence was less, and this not from pretentiousness on the part of the doctor, but only as a part of the spirit of the age. How were they to account for this falling off in the respect in which medicine was held? First, the general modern physician was not a man of such wide learning as formerly. Medicine, ever a jealous mistress, now made such heavy claims on her followers that few could find time or energy to pursue abstract studies or refined scholarship. Science progressed so rapidly that many modern physicians could follow only special departments of practice. Experts were valuable, but they were now witnessing an undue amount of differentiation, and the erection of specialities of doubtful value. Some members, again, failed to commend the profession to the public either by their inflated pretensions, or an inherent inaptitude to adapt themselves to their social environment. Again, anything approaching extortion or greed, or extreme partisanship in political or religious matters, impaired the respect in which medical men should be held, living, as they ought to, in a spirit of comprehensive catholicity and charity. The premature announcement of discoveries and alleged cures was also mischievous. Such abortive results, hurried out of German laboratories for the most part, after occupying attention for a week or two, came to nothing, and yet were reckoned as failures in the field of legitimate medicine. They should try to grow robust in mind, and be level-headed and better fitted to hold their own among members of the other great professions. A vote of thanks was awarded by the gathering, on the motion of the Chairman, seconded by Sir T. R. Fraser, to Sir Dyce Duckworth for his address.

PROPOSED NEW DISPENSARY FOR GLASGOW.—A protest against the erection of the new dispensary, to which reference was made a week or two ago in this column, has been circulated for signature among the practitioners in the district of Anderston. The grounds of the protest are that the neighbourhood is fully supplied by the Western Infirmary, Parish Council Dispensary, and Parochial medical offices, and that there has been no expression of desire that a new dispensary should be erected from the inhabitants of the district.

ROYAL HOSPITAL FOR SICK CHILDREN, EDINBURGH.—The Directors have appointed Dr. J. S. Fowler to be physician to the hospital, *vice* Dr. T. M. Burn Murdoch, who has resigned.

LETTERS TO THE EDITOR.

THE DECLINING BIRTH-RATE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Whilst thanking you for the space previously accorded to me in the discussion of this important subject, I should be glad, in order to prevent confusion, if you will allow me briefly to epitomise my arguments. The force I claim for these, if any there be, is that they are extremely simple, and, moreover, they are impregnable to statistics. Your correspondents will observe that I readily admit decadence of the

British nation is now taking place; further, that it must inevitably continue so long as we build up an insecure Empire at the expense of the British nation, which emigration implies; indeed, to quote Lord Avebury, as reported in yesterday's *Daily Telegraph*, emigration would take away the best of our working classes, leaving the loafer, the less industrious, and the least energetic at home. Your correspondents will further observe that what I join issue upon is that a declining birth-rate, although it may be indicative of deeply seated evils, is in no degree responsible for the decadance. On the contrary, the decline affords us a valuable opportunity of setting our house in order if only we avail ourselves of it. On the other hand, what could be more prejudicial to the health and prosperity of our nation than an enormously increasing surplus population, thereby adding fuel to the fire. Mr. Lloyd-George tells us "there are ten millions in this country enduring year after year the torture of living on, or lacking a sufficiency of the bare necessaries of life." Sir Henry Campbell-Bannerman also tells us "there are twelve millions of people in this country living on the verge of starvation." Now, it is obvious that any increase of progeny amongst these would intensify the melancholy condition of things existent. On the other hand, an increase amongst the already overburdened middle-class must compel these either to join in the emancipation scheme (it could not reduce the 10 or 12 millions just referred to), or to rapidly degenerate from want of adequate means to sustain a healthy environment.

I am, Sir, your truly,
CLEMENT H. SERS.

Brighton, November 3rd, 1906.

VIOLET LEAVES AND CANCER.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I fear that the article on this subject in your current issue may lead to some misapprehension. It is true that, after many months of work, I have been unable to isolate any definite chemical principle from violet leaves, although I have obtained very strong evidence of the presence of a glucoside. But a paper read by Dr. W. A. Potts, of the Birmingham University, at the recent meeting of the Therapeutical Society in London, conclusively proves, I think, that although there is no ground for the extravagant hopes which have been raised as to the leaves proving curative in cases of cancer, they have, undoubtedly, therapeutic activity, particularly of an anodyne and antiseptic nature. At the same time, as Dr. Potts has shown, the very activity of the leaves constitutes a danger when they are used by unskilled persons, their administration being contra-indicated in patients with feeble hearts.

I am, Sir, yours truly,
H. WHIPPELL GADD.

Exeter, November 5th.

THE GREAT ORMOND STREET HOSPITAL FOR SICK CHILDREN.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Those who know London well would probably agree that the district which lies around Great Ormond Street is the most crowded and trying for the children of those who live in it. At one time the Seven Dials district was perhaps worse; but the great changes that have been carried on of late in the West Central parts are clearing away the unhealthy courts and alleys where the poor children were being reared by a class of parents far less capable than those that live and work in the parts lying far away in the East of London.

The question that the Duke of Fife's letter to *The Times* suggests is whether the ills arising from bad sanitation and high temperature can possibly be much relieved by the crowded treatment of a hospital out-patient department, for the maladies are not such that much good can be done by a special ward and a few admissions into it. If the object of this hospital is to provide for the neighbourhood in which it stands, it would be better to make a great change in the mode in which the work has been carried on for many years, and remove the chronic and surgical cases to a better atmosphere and healthier surroundings. That kind of work which the Duke of Fife considers proper for the Children's Hospital would be far better done on the old dispensary system, and it would be well for those interested in the hospital to watch carefully the dangers that may arise in the spread of infectious disease by crowding large numbers of out-patients suffering from contagious and infectious diseases in the waiting rooms.

I am, Sir, yours truly,
OBSERVER.

London, November 5th, 1906.

OBITUARY.

F. W. NEWCOMBE, J.P., M.D., M.S.DURH.

WE regret to announce the death of Dr. Frederick W. Newcombe, J.P., of Gateshead, which took place on October 26th, after a brief illness. Dr. Newcombe was educated at Durham University and the Newcastle College of Medicine. He took the degrees of Doctor of Medicine and Master in Surgery at Durham University, winning also the University Scholarship, and Medals in Medicine and Surgery. He commenced practice in Gateshead, which continued to be the place of his residence for the remainder of his life. Dr. Newcombe was a popular medical man, and built up a large practice. He was also an honorary physician to the Dispensary and medical officer of the Abbot Memorial School, and a certifying surgeon under the Factory Act. Some ten years ago he was appointed a Justice of the Peace for Gateshead.

LEWIS SMYTHE, M.R.C.S., L.S.A., M.D.GLAS.

WE regret to announce the death of Dr. Lewis Smythe at his residence Lewes, in his 88th year. Born at Dublin, the deceased gentleman took his degree as Doctor of Medicine at Glasgow University as early as 1840. He took his M.R.C.S. the previous year, being elected Fellow in 1861. In 1852 he qualified for L.S.A. London. He came to Lewes about sixty years ago. Owing to advancing years Dr. Smythe retired in 1893. For many years he acted as surgeon to the East Sussex Constabulary at Lewes, but he relinquished this office twelve years ago, and was succeeded by Mr. Fawssett.

SAMUEL AIRD JOLLY, L.R.C.S., L.R.C.P., ED., L.F.P.S., GLASGOW.

DR. S. AIRD JOLLY, whose death occurred last week at his residence, Acton, had been for many years medical officer to the Brentford Board of Guardians, and was also one of the honorary medical staff of the Acton Cottage Hospital. He took the diploma of the Edinburgh Colleges in 1876, and later became L.S.A. London.

SPECIAL ARTICLE.

A SIDELIGHT ON MEDICAL EDUCATION.

As our readers are aware, articles under the above title have been appearing at intervals for some years back in the columns of the *British Medical Journal*. These articles were based on the figures of rejections and successes at the examinations for admission to the various medical services—Navy, Army and Indian, and their avowed intention was to throw "a sidelight upon the educational methods and curricula in force in different parts of the United Kingdom." (*Brit. Med. Journ.*, Jan. 7th, 1905). Attention, it was claimed, was drawn "to the valuable light which an analysis of a sufficient number of them might be made to throw upon the efficiency of the different methods of tuition in vogue in different parts of the Kingdom, as gauged by the success of candidates who held respectively either English, Scottish, or Irish diplomas or degrees." (*Brit. Med. Journ.*, Dec. 3rd, 1904).

We have ourselves, in commenting from time to time on these articles, pointed out the many fallacies which underlie such an argument as that suggested in the last sentence. One has no right to assume that the candidates coming from the different schools are equally fairly representative of their schools, and, indeed, there are strong indications to believe that they are not. The tables as quoted give us no information as to the ages of the candidates, or as to the way in which they have spent their time in the interval between obtaining their diplomas and presenting themselves for the service examinations. The examinations, moreover, are, or have been till lately, London examinations, a point to which we shall presently return.

In spite of the admission that results must be based on "an analysis of a sufficient number," we find over and over again conclusions drawn from an absurdly inadequate number of figures. Thus, to take the first example at hand (Table VII., Supplement to *Brit. Med. Journ.*, June 2nd, 1906), we find that eight groups of candidates are each credited with 100 per cent. qualified, but on looking at the actual numbers of candidates on which the percentages are estimated, we find them to vary from 52 for the English Conjoint Board to 1 for Birmingham University!

The tables of our contemporary have, therefore, appeared to us vitiated both by their structure and by the assumptions on which they were based, and we have never troubled to analyse them with care. Professor Dixon, of Dublin, has taken this trouble, and some of the results are, as he mildly puts it, "remarkable." His communication, with the editorial comments thereon, appear in the *British Medical Journal* of the 27th ult. Not only are the conclusions vitiated in the way we have pointed out, but the tables show glaring and gross inaccuracies. In the analyses published on June 3rd, 1905, the average proportion of success to candidates is given in three different tables as 33.9, 54, and 47.8 respectively. All these figures are wrong. In fact, in Tables IV., V., VI., VII., VIII. of this date, the average given at the bottom in each case is wrong. The mistake apparently arose because the compiler, to obtain a gross average, added together a number of independent averages and then divided the result by the number of averages so treated. The mistake in some cases is so great as between 64.8 and 81. This is the more notable in that it is inconsistent with the results obtained in another way by the same compiler, and given in the same series of tables. The other tables are not more trustworthy.

One would have expected some answer to Dr. Dixon's criticisms, but the editor airily remarks that they "in nowise really affect the essential structure of the tables," and that "conceivably they are well founded, conceivably they are otherwise; but in any case it is scarcely worth while to devote time and space to their consideration." Now, figures are either right or wrong; in mathematics there are not two sides to any question. If the figures in the *British Medical Journal* are correct they should be defended; if not they should be withdrawn. As it is, certain conclusions have been based on figures alleged to be inaccurate, and instead of admitting an error, the *British Medical Journal* claims that the conclusions stand even if the figures fall.

We mentioned above that the Service examinations are, or have been, London examinations, and that thereby provincial, Irish and Scottish candidates are, or were, at a certain disadvantage. Professor Dixon has also raised this point, but he shows that whereas some years ago London carried off by far the largest proportion of successes, nowadays, as the requirements of the examinations are becoming more widely understood, and, we may add, as examiners are chosen from a wider area, successes are becoming more evenly distributed. The *British Medical Journal*, however, sees something "unpleasant" in this suggestion. Nevertheless, there is no imputation of unfairness to anyone in stating the obvious fact that a candidate examined by his own teachers, possibly on clinical cases he has already seen, has certain advantages over a candidate from a distance. To quote the *present* list of examiners in reply to this suggestion is somewhat evasive, as the inequality in results between the London school and others is fast disappearing. Even taking the present list, however, London has an undue preponderance of examiners, in proportion to the number of candidates from each school. The list, as quoted in our contemporary, consists of the names of three London gentlemen, and of one each from Cambridge, Dublin, Edinburgh, Belfast, and Aberdeen.

BELFAST.

CONSUMPTION IN COUNTY ANTRIM.—A meeting was held last week in Ballymena, to consider the question of the erection of a sanatorium for consumptives for County Antrim. Delegates attended from Ballymena and Larne Urban Councils, and Ballymena, Antrim, and Larne Rural Councils. Dr. Clibborn, medical inspector of the Local Government Board, was also present. A resolution in favour of the erection of a sanatorium was passed unanimously, and a committee appointed.

THE HEALTH OFFICER AND THE CITY COUNCIL.—At the monthly meeting of the Belfast Corporation last week, the recent appointment of Dr. Bailie as medical officer of health was again under discussion, one of the members of the Council asking for the production of a letter said to have been received from the Local Government Board. The Chairman of the Public Health Committee, Dr. King-Kerr, did his best to keep the letter dark, and even professed ignorance of its contents, saying he had not heard it read. His absurd efforts were ably seconded by his clique, with the result that the Corporation refused to order the production of the letter. Naturally this gave the widest publicity to the fact that something was being kept secret, and to the delight of the city the letter, dated October 11, was published in full in the *Northern Whig* on Friday last. It is a scathing condemnation of the job perpetrated by the Corporation, and must be most galling to those who put Dr. Bailie in office, more especially as they know the citizens generally agree with every word of it. But the idea that such a letter could be successfully suppressed speaks volumes for the mental powers of these gentlemen on the Corporation. One correspondent in a daily paper remarks that the only reason he can attribute to Dr. King-Kerr for his action in the matter is a wish on his part to be in the fashion in possessing "embarrassing letters"!

NEW BOOKS AND NEW EDITIONS.

The following have been received since the publication of last list:—

JOHN BALE, SONS, AND DANIELSSON, LTD. (London.).

A Few Hints on the Care of Children at Sea. By Samuel Synge, M.A., M.D., &c., &c. Pp. 30. Price 1s. net.

Pulmonary Phthisis: Its Diagnosis, Prognosis, and Treatment. By H. Hyslop Thomson, M.D. Pp. 188. Price 5s. net.

BAILLIERE, TINDALL AND COX (London).

The Nature and Treatment of Cancer. By John A. Shaw-Mackenzie M.D.Lond. Fourth Edition, revised. Pp. 107. Price 2s. 6d net.

On Retro Peritoneal Hernia: Being the "Arris and Gale" Lectures on the Anatomy and Surgery of the Peritoneal Fossa, delivered at the Royal College of Surgeons of England in 1897, by B. G. A. Moynihan, M.S., F.R.C.S. Second Edition, revised and in part re-written, by the author and J. F. Dobson, M.S., F.R.C.S. Illustrated. Pp. 195. Price 7s. 6d. net.

The Use of X-Rays in General Practice. By R. Higham Cooper, L.S.A. Illustrated. Pp. 98. Price 2s. 6d. net.

High Frequency Currents. By H. Evelyn Crook, M.D., B.S.Lond., F.R.C.S.Eng. Illustrated. Pp. 206. Price 7s. 6d. net.

Lectures on Diseases of the Lungs. By James Alexander Lindsay, M.D., F.R.C.P.Lond., M.A. Second Edition, enlarged and re-written. Pp. 509. Price 10s. 6d. net.

Syphilology and Venereal Disease. By C. F. Marshall, M.D., M.Sc., F.R.C.S. With 5 plates. Pp. 509. Price 10s. 6d. net.

Minor Maladies and their Treatment. By Leonard Williams, M.D., M.R.C.P. Pp. 383. Price 5s. net.

The Sigmoidoscope: A Clinical Handbook on the Examination of the Rectum and Pelvic Colon. By P. Lockart Mummery, B.C. Cantab., F.R.C.S.Eng. Pp. 88. Price 3s. 6d. net.

Transactions of the Medico-Legal Society for the Year 1905-1906. Edited by R. Henslowe Wellington and Stanley B. Atkinson, M.A., M.B. Vol. III. Pp. 122. Price 7s. 6d. net.

William Blackwood and Sons (Edinburgh).
The $CHCl_3$. Problem. By Richard Gill, B.Sc., &c., &c. Price, 2 vols., 10s. net.

Cassell and Co., Ltd. (London).
Submucous Excision of Deviations and Spurs of the Nasal Septum. By St. Clair Thomson, M.D., F.R.C.P., F.R.C.S. Pp. 48. Price, 1s. net.
The Health Reader. By W. Hoskyns Abrahall, with an Introduction by Sir Victor Horsley, F.R.S., F.R.C.S. Illustrated. Pp. 277.

Darling and Sons, Ltd. (London).
Thirty-fourth Annual Report of the Local Government Board, 1904-1905. Supplement containing the Report of the Medical Officer for 1904-1905. Pp. 428. Price 4s.

Davos Printing Co., Ltd. (Davos).
Davos as Health-Resort: A Handbook, with Introduction by W. R. Huggard, M.A., M.D. Illustrated. Pp. 316.

George Gill and Sons, Ltd. (London).
Nursing at Home. By J. D. E. Mortimer, M.B., and R. J. Collie, M.D. Pp. 128. Price 1s. 6d. net.

Henry J. Glaisher (London).
Clinical Lectures on Neurasthenia. By Thomas D. Savill, M.D. Lond. Third Edition, revised and enlarged. Pp. 216. Price 7s. 6d. net.

Charles Griffin and Co., Ltd. (London).
Outlines of the Diseases of Women. By John Phillips, M.A., M.D., &c. Illustrated. Fourth Edition, revised and enlarged. Pp. 282. Price 7s. 6d.

J. Jacobs (London).
Hypnotism and Suggestion. By Edwin Ash, M.B., B.S.Lond. M.R.C.S.Eng. Pp. 136. Price 4s. net.

H. K. Lewis (London).
Medical Electricity: A Practical Handbook for Students and Practitioners. By H. Lewis Jones, M.A., M.D. Fifth Edition. Illustrated. Pp. 519. Price 12s. 6d. net.
The Röntgen Rays in the Diagnosis of Diseases of the Chest. By H. Walsham, M.A., M.D., and C. Harrison Orton, M.A., M.D., Illustrated. Pp. 80. Price 6s. net.
Æquanimitas: With Other Addresses to Medical Students, Nurses, and Practitioners of Medicine. By William Osler, M.D., F.R.S. Second Edition. Pp. 475. Price 8s.
Refraction of the Eye. By A. Stanford Morton, M.B., F.R.C.S.Eng. Seventh Edition. Pp. 96. Price 3s. 6d.
Elements of Practical Medicine. By Alfred H. Carter, M.D., M.Sc. Ninth Edition. Pp. 614. Price 10s. 6d.

Longmans, Green and Co. (London).
Helouan: An Egyptian Health Resort, and How to Reach It. By H. Overton Hobson, M.D.Edin. Illustrated, and two maps. Pp. 88. Price 2s. 6d. net.

Macmillan and Co., Ltd. (London).
Collected Papers on Circulation and Respiration. First Series. By Sir Lauder Brunton, M.D., &c., &c. Pp. 696. Price 7s. 6d. net.

Methuen and Co. (London).
The Hygiene of Mind. By T. S. Clouston, M.D., F.R.S.E. Illustrated. Pp. 284. Price 7s. 6d. net.

James Nisbet and Co., Ltd. (London).
Experiments on Animals. By Stephen Paget, with an Introduction by Lord Lister. Third and Revised Edition. Pp. 387. Price 4s. 6d. net
Alcoholism: A Chapter in Social Pathology. By W. C. Sullivan, M.D. Pp. 214. Price 3s. 6d. net.

Rebman, Ltd. (London).
The Diseases of Women: A Handbook for Students and Practitioners. By J. Bland-Sutton, F.R.C.S.Eng. and Arthur E. Giles, M.D., B.Sc.Lond., F.R.C.S.Edin. Fifth Edition. Illustrated, Pp. 536. Price 11s. net.
The Development of the Human Body. By J. Playfair McMurrich, A.M., Ph.D. Second Edition, revised and enlarged. Illustrated. Pp. 539 Price 14s. net.
The Influence of the Menstrual Function on Certain Diseases of the Skin. By L. Duncan Bulkley, A.M., M.D. Pp. 108. Price 5s. net.
Hypnotism; or, Suggestion and Psychotherapy. By Dr. August Forel. Translated from Fifth German Edition by H. W. Armit, M.R.C.S., L.R.C.P. Pp. 370. Price 7s. 6d. net.

The Walter Scott Publishing Co., Ltd. (London).
Race Culture or Race Suicide: A Plea for the Unborn. By Robert Reid Rentoul, M.D., &c., &c. Pp. 182. Price 7s. 6d. net.

The Scientific Press, Ltd. (London).
Notes on General Practice. By S. M. Hebblethwaite, M.D. Pp. 78. Price 3s. 6d. net.

W. B. Saunders and Co. (London).
The Illustrated Medical Dictionary. By W A. Newman Dorland, A.M., M.D. Fourth Edition revised and enlarged. Pp. 836. Price 19s. net.

Smith, Elder and Co. (London).
Artificial Feeding of Infants. By W. B. Cheadle, M.D.Cantab., F.R.C.P. Sixth Edition, revised by F. J. Poynton, M.D.Lond., F.R.C.P.
Auscultation and Percussion, together with the other Methods of Physical Examination of the Chest. By Samuel Gee, M.D. Fifth Edition. Pp. 325. Price 6s.

Sudan Government, Dept. of Education. (Khartoum.)
Second Report of the Wellcome Research Laboratories at the Gordon Memorial College, Khartoum. By Andrew Balfour, M.D., B.Sc., &c., &c. Pp. 255

John Wright and Co. (Bristol).
Golden Rules of Medical Evidence. By Stanley B. Atkinson, M.A., M.B., &c. Pp. 63. Price 1s.
A Guide to Urine Testing for Nurses. By Mark Robinson, L.R.C.P., L.R.C.S.Edin. Third Edition, revised. Pp. 56. Price 1s. net.
Lectures on Massage and Electricity in the Treatment of Disease. By T. S. Dowse, M.D., &c. Sixth Edition, revised. Pp. 447 Price 7s. 6d. net.
Woman's Health and How to Take Care of It. By Florence Stackpoole. Second Edition, revised. Pp. 165. Price 1s. 6d. boards, 2s. 6d. cloth.

Edward Arnold (London).
The Diagnosis of Nervous Diseases. By Purves Stewart, M.A., M.D., F.R.C.P. Illustrated. Pp. 380. Price 15s. net.

REVIEWS OF BOOKS.

CLINICAL STUDIES OF NUTRITIONAL DISORDERS (*a*)

This small work forms a valuable supplement to the volume entitled "Nutrition of the Infant," by the same author, which was favourably reviewed in these columns in the autumn of 1904. The writer is well known as an enthusiastic worker on infant-feeding. The book before us gives abstracts of a number of typical cases of malnutrition which have been under Dr. Vincent's care at the Infants' Hospital. The plan adopted is to give a very brief history of each case, and then a full account of the milk or other mixture on which the patient was fed, together with notes on the infant's after-progress. The milk mixtures are given in percentages of their ingredients—namely, fat, lactose, whey-proteids, and caseinogen, while the degree of alkalinity is always noted. A careful perusal of these case-histories is very instructive, and although no rule-of-thumb method can be followed in infant-feeding, still, by following the author's methods the practitioner will be better equipped for the management of difficult cases which constantly present themselves for treatment in daily practice. Infant-feeding has a real scientific basis, and Dr. Vincent is a strong adherent to the method of percentage feeding. His results are excellent, and he must accordingly be congratulated thereon. His book is of great interest and importance, and is well worthy a place in the list of really useful treatises on the subject of infant-feeding. It is well-arranged, nicely printed, and neatly bound.

THE PROLONGATION OF LIFE. (*b*)

The longing for life and the dread of death are almost natural characteristics of the young and vigorous. But with advancing years physical enfeeblement, mental limitation, and lack of the powers on which depend the ability to make ready adjustments, old age is only too apt to become wearisome, querulous, and oftentimes burdensome. The art of prolonging life to a joyous and serviceable eventide needs to be cultivated. It is little wonder that the charming lecture published in this attractive volume should have found such favour as to call for a second edition. It is written by one who, having borne the heat and burden of the day, now views the long road with the satisfaction of a journey well travelled and a rest rightly won. Sir Hermann writes with the charm and experience of the philosophic physician who has blended science with human sympathy. The book is one to be studied by the aged, but it is full of lessons for the young. Every physician should read it, and any intelligent layman may study it with advantage. It is a guide to pure living, high thinking, and rational regulation of life's duties and pleasures. The author tells us that in his analysis of the records of more than one hundred cases of long-lived persons, he found that "by far the majority of them were temperate; were small meat eaters; lived much in the open air; led an active life; many, a life of toil with great restrictions as to food and comforts; that most of them were early risers; that a great number of them had a joyful disposition, and performed their work cheerfully; and that only a few were intemperate or idle and lazy persons."

(*a*) "Clinical Studies in the Treatment of the Nutritional Disorders of Infancy." By Ralph Vincent, M.D., F.R.C.P., Physician to the Infants' Hospital. London: Baillière, Tindall, and Cox. 1906. 3s. 6d. net.

(*b*) "On Means for the Prolongation of Life." Second and enlarged edition of a Lecture delivered before the Royal College of Physicians on December 3rd, 1903. By Sir Hermann Weber, M.D., F.R.C.S. Pp. 104. London: John Bale, Sons and Danielsson, Ltd. 1906.

MEDICAL NEWS IN BRIEF.

A Leeds Home.—Bodies alleged to have been burnt.

STARTLING evidence as to the real character of a "maternity home" in Leeds, was heard last week, when serious charges were made against Elizabeth Miller (45), a Leeds nurse, who had controlled the home.

A single woman, living in Leeds, stated that in response to an advertisement she saw the accused on September 25th. Witness had told Miller of her condition in a letter prior to the interview. On the occasion of the interview the prisoner said: "What I am going to tell you is strictly private and confidential between ourselves."

Mr. Atter: Were any terms mentioned between you and her?

Mr. Atter: She said if I could get a certain sum for her she could do something for me.

His Worship: Did she mention the sum?

Witness: Yes, £15.

Witness was unable to find the money and left.

A widow named Phyllis Hibbert then entered the witness box, and spoke to having been under the treatment of the prisoner, whom she first saw on September 6th last. Miller remarked to her at the initial interview that if she would pay £10 there would be no need to go to the end.

Witness went to live in the house and Miller gave her some brown liquid in a cup, and also some pills.

Mr. Atter: Did she say what would happen to anybody if anything was said?

Witness: She said if I repeated what she had said or had done, she would get ten years, and I should get five.

Mr. Atter: Did she say anything else?

Witness: She said, "You know I have a doctor behind me."

Mr. Atter then intimated that he was going to call a witness who would speak as to the way in which the bodies had been disposed of. "I shall be able to prove," said Mr. Atter, "if this evidence is admissible, that a number of bodies have been disposed of by burning."

A woman named Annie Farrar stated that fifteen months ago the form of a child was put under the copper.

Who put it under the copper?—Nurse Miller.

Where did the child come from?—Out of the bedroom.

Dr. Alexander B. S. Stewart, of Woodhouse Square, stated that on Sunday a fortnight ago he saw the prisoner, and he told her that he had had a woman down to see him, who said that she had paid the prisoner £15, ten of which were for witness's fee, Nurse Miller said the £15 was for lodgings, and she flatly denied that she had said that £10 was for witness.

He had never received £10 for attending on any of the patients at the home. The biggest fee he ever got from the prisoner was £3. He looked upon the home as a proper maternity home, and saw nothing improper about it. He had been summoned there in certain cases.

The further hearing was adjourned until Wednesday next.

Christian Science.

AT Acton, Robert F. Chisholm, 69, an architect, of Bedford Park, was charged on a warrant with feloniously killing his son, William M. Chisholm, æt. 10, by wilfully neglecting him.

Mr. Gill said the Christian Scientists objected to medical aid. The boy became ill at school, and on taking to his bed a "healer" was called in, but the boy died from diphtheria. The decisions on the point were to the effect that if a man neglected to do certain things in consequence of which his child's death was accelerated, he was guilty of manslaughter. He submitted that though Christian Scientists might be entitled to carry out their ideas upon themselves, they ought not to be allowed to practise upon those too young to judge for themselves.

Dr. Bishop, Acton, stated that he was summoned to the house of the prisoner, who said his son was dead, and that he thought it was a case of mumps. Witness examined the body of the boy, and, being satisfied that death had occurred, communicated with the coroner. Witness then proceeded to state the condition of the body, and the symptoms which pointed, in his opinion, to a case of diphtheria. If the deceased had been properly treated his chances of recovery would have increased. The fact that he lived twelve days showed that he had good vitality and strength.

Evidence given before the coroner showed that Miss Turner, the "healer," suggested that a doctor might be called in, as Mrs. Eddy, the head of the sect, had advised this in infectious cases.

A remand was ordered.

A Medical Man charged with Murder.

A GREY-HAIRED man of fifty-seven, named Arthur Raynor, described as a physician and surgeon, of 83, Palmerston Road, Kilburn, appeared last week at Marylebone, charged with the wilful murder of Anne Lillian Martin, a young married woman, æt. 32, living at Kentish Town.

The accused, who appeared to be suffering from partial paralysis, was assisted into court and allowed to remain seated during the hearing.

Detective Inspector Neil described how he found Raynor the previous evening in the back basement room of 83, Palmerston Road. He explained that prior to her death Mrs. Martin made a statement before a magistrate as to the treatment she had received at the hands of the accused, and that he had performed a certain operation. The accused was also told that two doctors had stated that the woman died from septic poisoning. An instrument was found in the room, but the accused said that he used it for a perfectly innocent purpose.

Raynor was remanded in custody.

Opening of Committee on Industrial Diseases.

A departmental committee was recently appointed to "inquire and report what diseases and injuries, other than injuries by accident, are due to industrial occupations, are distinguishable as such, and can properly be added to the diseases enumerated in the Third Schedule of the Workmen's Compensation Bill, 1906." The work thus outlined is of great importance, and includes the investigation of the following diseases and injuries, viz.: gradual poisoning from the vapour of carbon disulphide, dinitrobenzol, dinitrotoluol, and anilin; gradual poisoning from carbonic oxide gas, sulphuretted hydrogen gas, and chlorine gas; alkaloidal poisoning from African boxwood in shuttlemaking; illness set up by nitrous fumes, hydrochloric acid fumes, ammonium chloride fumes, and sulphur fumes; compressed air illness (caisson disease); chrome ulceration of the skin; various trade eczemas; fibrosis of the lungs from inhalation of silicious or metallic particles (potter's asthma and grinder's phthisis); pneumonia from inhalation of basic slag dust; miners' nystagmus and miner's "beat knee" and "beat hand"; neurosis due to vibration; cardiac dilatation in slate quarries; and glanders. Correspondence relating to the inquiry should be addressed to Frank Elliott, Esq.

secretary to the committee, at the Home Office, Whitehall, S.W. Anthrax, ankylostomiasis, and poisoning by lead, mercury, phosphorus, and arsenic are already included in the Third Schedule of the Workmen's Compensation Bill, and are not, therefore, within the Committee's terms of reference.

Scabies in relation to Blankets and Sleeping Suits for Soldiers.

THE following letter from *The Broad Arrow* is of much suggestive significance, especially in view of a recent notorious "ragging" case:—

"SLEEPING SUITS FOR SOLDIERS.

"Sir,—I think very few sensible people will disagree with Surgeon-General Evatt in his views as to the provision of sleeping suits for soldiers. There can be no question as to their usefulness from a sanitary standpoint. At the same time, one wonders why he has thought it necessary to insinuate that itch amongst soldiers is produced and propagated by means of army blankets. I think there is not much doubt that itch is usually picked up outside barracks, and it very often happens that some form of venereal disease is contracted at the same time. An examination of medical history sheets, of men who have had some years' service, will usually show several entries for venereal disease and an occasional one for itch. The disease is usually found either amongst newly-joined recruits, or in men who have just returned off furlough. The men are sent to hospital with their 'filthy blankets' and the whole of their clothing. The latter is put through the hospital disinfector, and the men are treated. That ends the trouble. Non-commissioned officers in charge of rooms are more intelligent than they used to be, and the men themselves are quite averse to allowing anyone with any skin disease to remain in their midst. Men returning off furlough are inspected with a view to detecting this disease. Weekly sanitary inspections also serve the same purpose. Itch is not by any means the prevalent disease in army life nowadays that one would be led to expect by reading Surgeon-General Evatt's letter. In this garrison there have been up to the end of October thirty-nine cases. The average strength has been about 3,500. As regards treatment by sulphur, I think that as soon as it becomes generally known what the powers of balsam of Peru are, when applied to the skin of itch cases, the former remedy will cease to be used.—I am, etc.,"

F. J. W. PORTER (Major), R.A.M.C.

Colchester, October 29th.

Medical Sickness and Accident Society.

THE usual monthly meeting of the Executive Committee of the Medical Sickness, Annuity, and Life Assurance Society, was held on October 26th. There were present—Dr. de Havilland-Hall, in the chair, Dr. J. Brindley James, Dr. J. W. Hunt, Dr. F. S. Palmer, Dr. Walter Smith, Dr. St. Clair, B. Shadwell, Dr. F. J. Allan, Dr. H. A. Sansom, Mr. J. F. Colyer, and Dr. J. B. Ball. The Society has had a moderate Sick Claim List during the summer months, and has added an appreciable amount to its already large reserves. The number of new entrants has been more than the average, but the Committee appeal to the members to bring under the notice of their medical friends the many advantages obtained by those who join the Society. In this way the useful work which it is doing could be largely extended. Prospectuses and all other particulars on application to Mr. F. Addiscott, Secretary, Medical Sickness and Accident Society, 33, Chancery Lane, London.

Royal University of Ireland.

THE Senate of the Royal University have adopted the following resolution:—"That in the judgment of the Senate of the Royal University, it would be disastrous to the interests of education in Ireland, and gravely injurious to the welfare of the country, to concentrate the control of higher education in one University."

Irish Medical Association.

WE regret to hear that Dr. Leonard Kidd, of Enniskillen, has resigned his membership of the Irish Medical Association. We trust that we have been misinformed, as the resignation of such men is fraught with the gravest danger to the Association.

PASS LIST.

Royal College 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 October 31st, with the following results:—

First Examination, Five Years' Course.—Of 28 candidates entered, the following eight passed the examination: Bhairawnath Dinanath Khote, Bombay; Robert Eric Noel Martyn Clark, Punjab; Andrew Dawson Turnbull, Edinburgh; William James Moore, Dunoon; Alexander Fitchie Taylor, Fraserburgh; John Adami, Malta; William James Hogg, Birmingham; and Harry Russell Macnab, Downpatrick; and one passed in Physics, four in Biology, and one in Chemistry.

Second Examination, Four Years' Course.—Of two candidates entered, the following one passed the examination: George Vernon Edwardes, Cheshire.

Second Examination, Five Years' Course.—Of 26 candidates entered, the following 13 passed the examination: George Francis Hegarty, Cork; Cornelius O'Herlihy, Cork; James Thomas Gwynne Jones, Wales; Zerk Daniel Lotter-Luther, Cape Colony; Charles William Gee, Wigan; Sydney Granville Tibbles, Nottingham; Reginald Andrew Hosegood, Swinton; George FitzWilliam Forde, Ballygeany; Evan Aynsley Klein, British Guiana; Denis Michael O'Sullivan, Ireland; William Clair Leonard Malone, Australia; Karl Frederick Percy Richard Gover, British Guiana; and George Noel Braham, Bath; and one passed in Anatomy, and one in Physiology.

Third Examination, Five Years' Course.—Of 29 candidates entered, the following 12 passed the examination: Eduljee Perozshaw Meherjee, Bombay; Maria Shepherd Allen, Cheadle; Augustus Jourdain Kelsey, Mauritius; Zerk Daniel Lotter-Luther, Cape Colony; Alexander McMurray, Belfast; Hugh Clement de Souza, Rangoon; William Henderson, Scotland; Joseph Louis Pinto, Portuguese India; Frank Humphrey Kiddle, India; Andrew Downie Macfie, Scotland; Edward Lewis, Anglesey; and Francis Wardlaw Milne, Helensburgh; and three passed in Pathology and two in Materia Medica.

Final Examination.—Of 82 candidates entered, the following 30 passed the examination and were admitted L.R.C.P.E., L.R.C.S.E., and L.F.P.&S.G.: Walter Bingham Kendall, Canada; Neil McLeod, Edinburgh; Charles Edward Preston, Canada; Lionel Langford Westrope, Shrewsbury; John Henry Morris Jones, N. Wales; Henry James Gorrie, Dundee; Merwanji Dinshah Printer, Bombay; Zilla Edith Da Costa, India; Henry Fleet Gordon, Canada; Dhunbai Maneckji Cama, India; Harold Lyons Hunt, Canada; Harry Ferguson Shepherd, Lisburn; Henry Ruddock Morehead, Co. Cork; John Clarke, Ballymena; Satya Charan Pal, Bengal; Emma Irwin, New Zealand; Thomas Mayne Reid Waddell, Tokio; Walter Hugh Pearless, Victoria; Tandalam Madhava Row, Kumbakonum; Lizzie Lyford de la Harpe, Ceylon; Percy Bateman, Cork; Robert Thomas Aloysius Patchett, Lancashire; Eduljie Perozshaw Meherjie, Bombay; David Graham Barkley, Edinburgh; Capel Geary Dyer, Hampshire; Richard Baring Davidson, Congleton; Munchersha Byramji Irani, Bombay; James Augustus Robertson, British Guiana; Arthur Donald Roberts, India; and John Henry Peter Wijesinghe Ceylon; and 16 passed in Medicine and Therapeutics, 3 in Surgery and Surgical Anatomy; 17 in Midwifery; and 13 in Medical Jurisprudence.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS. ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT MEDICAL LITERATURE.

Ascites as a Prognostic Factor in Alcoholic Cirrhosis of the Liver.—Ramsbottom (*The Med. Chronicle*, October, 1906) discusses the significance of this symptom in the prognosis of alcoholic cirrhosis. His investigation is based on 68 fatal cases of alcoholic cirrhosis of the liver, and simple peritonitis, met with in the Manchester Royal Infirmary during the last twenty years, upon which post-mortem examinations were made. Fourteen years ago Hale White, in a paper on this subject, claimed that ascites is of the gravest prognostic significance in that type of cirrhosis of the liver usually ascribed to alcohol, in that when once ascites appears, unless some degree of chronic peritonitis exists, the patients never survive long enough to be tapped twice. In the 68 cases investigated by Ramsbottom 45 were cases of uncomplicated alcoholic cirrhosis, but in only 39 of these were the notes complete enough for the duration of the ascites to be ascertained. Of these cases seven showed temporary improvement after ascites had occurred, and for periods varying from two to ten months the patients were able to resume their work, but in only one case was there any sustained improvement after paracentesis abdominis had been performed. In the remaining 32 cases the average duration of life after the appearance of ascites was 98.6 days. Of the 45 cases of uncomplicated cirrhosis 14 died before tapping was necessary, 14 were only tapped once, and 10 were tapped twice, and of the remaining seven cases only one survived long enough to require tapping more than five times. In the nine cases of simple chronic peritonitis the average number of days survived after the appearance of ascites was 624. In twelve cases where there was cirrhosis and peritonitis combined the average number of days survived after the appearance of the ascites was 360. From a comparison and investigation of these figures Ramsbottom draws the following conclusions:—"(1) That in the great majority of cases of alcoholic cirrhosis of the liver in which the peritoneum is not thickened as shown post mortem, ascites is a terminal event. (2) That there are a few cases of alcoholic cirrhosis of the liver which survive some considerable time after the appearance of ascites, and in which there is no evidence of chronic peritonitis revealed at the autopsy. (3) That there are again cases of alcoholic cirrhosis of the liver in which ascites is of much less prognostic significance, in that the fatal termination is even more remote from the incidence of this phenomenon. In such, post-mortem investigation invariably reveals the co-existence in a greater or less degree of chronic peritonitis, and they approach in clinical type the condition of simple chronic peritonitis." K.

Enuresis Nocturna.—Allen (*Jour. R.A.M.C.*, October, 1906) reports a case of this condition which occurred in a soldier of over ten years' service. The patient was brought under his notice with a view of invaliding him from the service, he having been treated for two months in hospital for incontinence without any benefit. On investigation it appeared that the condition had only appeared during the last few months, and the man had never suffered from it prior to enlistment. Some months previous to the onset of the incontinence this patient had been invalided home from India on account of enteric fever, and Allen found that the man was suffering from simple polyuria. This he believes to be an irritative polyuria due to the toxæmia of the enteric fever, and suggest this as an important causative factor in cases of incontinence occurring in adults. K.

The Immunity of Heart Cases from Phthisis.—Snow (*Amer. Jour. Med. Sciences*, October, 1906) states that whether organic heart diseases do or do not grant immunity from pulmonary tuberculosis depends on the presence or absence of a co-existing, long-standing passive hyperæmia in the pulmonary circulation. Thus it is found that organic valvular diseases of the right side of the heart which are productive of pulmonary anæmia are most frequently associated with phthisis; while similar diseases of the left side of the heart when accompanied by well-marked hypertrophy and dilitation are rarely followed by tuberculosis of the lungs, and not infrequently effect an extinction of a previously existing tuberculosis. These observations suggest that in the treatment of incipient phthisis patients should be urged to indulge in physical exercise in the open-air sufficient to produce "severe congestion of the lungs." This should be effected "not by mere gentle walking or driving, but running until the induced congestion of the lesser circulation interferes with the free action of the right ventricle and forces temporary rest." Snow quotes with approval the remark made half in jest by Elbert Hubbard that "tuberculosis is but a form of laziness." K.

Unrecognised Etiologic Factor in Summer Diarrhœa of Infants.—Walsh (*Med. Record, New York*, September 18th, 1906) calls attention to the cathartic property in the grasses which form the food of so many cows from spring to autumn. This property disappears when the grass is dried in the form of hay. The mortality curve follows the life of this form of vegetation, reaching its maximum in July, then gradually declining. Infants get the full physiologic effects, and often the toxic effects of the aperient properties in the milk from grass-fed cows. From October to May there is almost none of this diarrhœal tendency apparent. Sterilisation does not destroy this poison, which is a chemical one. The cow whose milk is used for infants should be kept off the pasture, and should be staff-fed, as in winter. The chemistry of the grasses, Walsh states, offers a comparatively new field for study. D.

Intestinal Origin of Pneumonia and other Pulmonary Infections.—Calmette (*Presse Medicale, Paris*, 1906), recently announced that tubercle bacilli fed to animals in his experiments passed rapidly through the intestinal wall, and were soon found in the lung, without leaving a trace of their passage. Similar tests were equally positive when finely pulverised charcoal or other insoluble particles were fed to the animals instead of tubercle bacilli. In another series of tests pneumococci were ingested by the animals in the same way, and with the same result—that is, the pneumococci were found accumulated in large numbers in the lungs with much congestion but no lesions. None of the animals sickened. It is probable that the animal organism is able to take care of these bacilli unless the vitality is depressed from some other cause. D.

Peptic Ulcer of the Œsophagus.—Jileston (*St. Louis Med. Review*, September, 1906 reports three cases, all of them terminating fatally. In the first case, that of a woman, æt. 58, the ulcer was situated 3 cm. above the cardiac opening of the stomach. The ulcer did not manifest itself until it perforated. In the second case, a man, æt. 59, the lower end of the œsophagus for a distance of 11 cm., was denuded of mucous membrane, except for a few small islands. The ulceration was very shallow, not involving the muscular coat. In a third case, a woman, æt. 37, there were several ulcers in the œsophagus, and also a chronic ulcer of the stomach, which perforated, causing the fatal peritonitis. D.

Effect of Dry Diet in Nephritis.—Ekehorn *Archiv. f. Klin. Chir., Berlin*, 1906) has been experimenting with a dry diet in cases of nephritis, and he found that

while in health the specific gravity of the urine increases in proportion to a decrease in its amount, in nephritis a dry diet lowers the freezing point of the blood. The amount of urine was reduced, but the sp. gr. did not rise to correspond. The kidneys were incapable of secreting a concentrated urine. D.

Anatomic Leucæmia without Leucæmic Blood.—Ewald (*Berlin Klin. Woch.*, 1906) describes a case with autopsy in which the symptoms indicated acute myeloid leucæmia running a fatal course in about seven weeks. The patient was a robust man of 37. The autopsy disclosed hyperplasia of the spleen, lymphomatous infiltration of the liver and kidneys, raspberry jelly bone marrow, hæmorrhage in kidney and stomach, fatty degeneration of heart with enlargement and pericarditis with adhesion. The microscopic findings were also those of leucæmia. At the same time the blood did not present any of the characteristics of leucæmia, and there were no pains in the bones and no enlargement of the peripheral glands. The lack of the latter and the negative blood findings, as well as the rapidly fatal course of the disease, spoke against splenic anæmia, and nothing was found to indicate a septic process. D.

Ocular Signs in Leucæmia.—Stock has studied the eye symptoms in leucæmia and Hodgkin's disease, and states that the so-called leucæmic retinitis is seen as often in lymphoid as in myeloid leucæmia; but, that from the retinal changes no differential diagnosis between the two varieties can be made. The distinctive bright yellow colouring of the back of the eye observed in some cases of leucæmia is probably produced by an accumulation of leucocytes in the choroid coat. In acute leucæmia, which is usually lymphatic, retinal changes have only rarely been observed. Still, in some cases extreme curving and dilatation of veins has been noticed, following which hæmorrhages into and characteristic cloudiness of the retina have taken place. As regards leucæmic tumours within the orbit, two theories of their origin may be held, according to the position they occupy. One is that they are merely hypertrophied pre-existing lymph masses, and the other is that they are metastatic growths, formed by proliferation of leucocytes which have escaped from the blood vessels. Probably both theories are correct. M.

Effect of Alcohol on Pancreatic Secretion.—Gizelt (*Pflügers' Archiv. f. d. grs. Physiol.*, Bd. 111, S. 620) makes a preliminary report of his investigations in connection with the above. He finds that when 50 cc. of a 10 per cent. alcoholic solution are introduced into the rectum or stomach of dogs who have a permanent pancreatic fistula, a secretion is set up in from 15 to 20 minutes, and persists for two or three hours. If the vagi nerves are previously cut, however, no secretion takes place. When the alcohol is injected subcutaneously a similar outflow of pancreatic juice takes place, but not when the alcohol is introduced directly into a blood-vessel. This last fact is supposed to be caused by the alcohol exerting an injurious effect on all the cells of the body, including the pancreas. This is supported by the fact that even the introduction of acid into the duodenum does not give rise to any secretion after the injection of alcohol in this way. Gizelt also finds that all the ferments are increased when alcohol is given by the stomach, and especially the fat-splitting one. The action of the alcohol is supposed to be on some precursor of the various enzymes concerned. M.

The Fat-Splitting Ferment of Gastric Juice.—Vollhard has proved that a fat-splitting ferment can be isolated from the gastric juice, and this has now been further investigated by Fromme (*Beitr. Z. Chem. Physiol. und Pathol*, Bd. 7, S. 51). The last-named author finds that a glycerine extract of the cardiac end of the gastric mucous membrane has a strong fat-splitting power, the power increasing with the length of time of extraction up to five days. A second and a third extraction even yields a juice of very considerable strength, and similar properties are found in the glycerine extracts made from dogs' stomachs. When, however, the mucous membrane is left exposed to the air for 24 hours, the extract is quite inert. This *lipase* differs from the other ferments of the stomach in being hindered in its action by small amounts of hydrochloric acid, while, like pepsin, it is also inert in the presence of alkalies. It will not traverse a filter, and does not combine with glycerine. M.

Rontgen Ray Examinations of Stomach and Intestines.—Since the bismuth method has come into use for X-ray examinations, some important observations on the morphology and the motor functions of the stomach and intestines have been made; thus, for example, X-rays have been found to be the method most agreeable to the patient for determining the position and state of the stomach. Still, up to this the screen has been almost alone employed, and very few photographs have been taken. Reider has now made several observations on the photographic plate (*Münch. Med. Woch.*, 1906, No. 3), using bismuth either in suspension or solution, or even mixed up with the ingredients of an ordinary meal. He has in this way definitely determined that the long axis of the stomach is vertical. Radiographs of the intestine, after giving bismuth by the mouth and in enema, rendered most of the intestine visible, with the exception of the sigmoid flexure and the rectum, which lie in the cavity of the lesser pelvis. The screen shows the bismuth traversing the small intestine rapidly, while in the large intestine the movement is much slower, and there is often a considerable delay at the ilio-cæcal valve. The transverse colon does not lie horizontally, but forms an arch convex downwards and forwards. The writer thinks that this method may prove most useful in the diagnosis of motor insufficiency of the stomach and intestines, and may also give some aid in the observation of the action of drugs such as purgatives. M.

Antipepsin.—When digestion experiments are carried out with undiluted gastric juice, it is found that digestion is less energetic than when the fluid has been diluted. Various substances which hinder the process may also be present, and these have been investigated by Blum and Fuld (*Zeitsch. für Klin. Med.*, Bd. 58). The authors find, in accordance with Schiff's statements, that they are able to confirm the above statement with reference to dilution in certain stomach diseases, and they also find that the property of becoming more active with dilution is better marked in juice obtained from a fasting stomach than in that obtained after a fish meal; it is also more marked when the secretion is abundant and being poured out rapidly. The hindering substance is in all probability a true antipepsin, a conclusion towards which Danilewski's investigations had already pointed. It is thermostabile, and can thus be separated from pepsin. The authors tried its effect in certain cases of disease, and found that it had a strong inhibiting effect on the hypersecretion found in carcinoma ventriculi and in chronic gastric catarrh. The antipepsin can be recovered from gastric juice that has been employed to digest various albumins, and is also present in commercial pepsin. It is strongly resistant to alkalies, and is precipitated by alcohol, but not by ammonium sulphate. M.

The Sanitation of Cairo.

IT is announced that the Egyptian Government has at last decided to undertake the sanitation of Cairo, and Mr. C. Carkeek James, a distinguished Anglo-Indian sanitary engineer, has been entrusted with the execution of a scheme. It is generally believed that the supply of a proper system of drainage will entail seven years' work and an expenditure of at least £E5,000,000, but all such estimates must be accepted with caution in the absence of sufficient *data*. Mr. James is, and will be for some time, engaged in a thorough study of the existing sanitary conditions o the capital.

NOTICES TO CORRESPONDENTS, &c.

CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to 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 proofs.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions, the same rule applies as to office; these should be addressed to the Publisher.

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.

CHANGE OF OUR OFFICE ADDRESS IN DUBLIN.

The Dublin Office of this Journal has been removed from 16 Lincoln Place to 18 Nassau Street. The latter premises are larger and more suitable, and will be open from ten to six daily, and on Saturdays from ten to two. Subscribers to the Journal and others desiring information regarding vacancies, *locum tenentes*, and medical matters in Ireland generally, can always obtain it by applying to the Manager either by letter or personally.

SUBSCRIPTIONS.

SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance.

DR. S. R.—None of the serums so far prepared for use in scarlet fever have gained any confidence in this country. Some Continental writers have found one or another of them hopeful.

OPHTHALMIC.—Dionin is a recognised agent. A 5 per cent. solution is valuable in deep-seated ocular pain. The first sensation on application is one of smarting.

DR. HALL.—The Thibetan medical philosophy is not unlike that of Christian Science, as the teaching is that all disease is the result of vice or wickedness. Their treatment is principally "natural," and their surgery barbarous.

NORTHUMBRIAN.—The salaries paid to assistant medical officers in the London County Council Asylums are according to seniority. The senior assistant receives £300, rising to £400, a year, with board, lodging, and washing. The junior gets £150, with the same emoluments. The others in proportion.

T. TWEED.—The St. Andrew's Ambulance Association is an independent organisation doing the same work in Scotland as the St. John's Ambulance Association does in England. If you are now resident in Yorkshire you should apply to the latter.

D. W.—The physician you name has not received titular distinction; but we should be glad to see his merit recognised if it pleased His Majesty to do so.

S. T. (Tunbridge Wells).—We cannot make any recommendation such as you desire. If you wish for an opinion on the question, you should consult your own medical attendant.

R. N.—The Mediterranean Commission found that the chief source of Malta fever was goat's milk, and the civil, naval, and military authorities in the island are now trying to suppress the use of such milk, or to insist on it being boiled.

MICRON.—"Modern Microscopy," by Martin J. Cole, 4s. net (Baillière, Tindall, and Cox) is the smallest book we know of. There has just been published a very good, larger book on the subject by A. E. Wright, M.D., price 21s. net (Constable and Co.).

J. E. HORTON.—Everything depends on the nature of the agreement. These partnership contracts are frequently the source of subsequent estrangement between friends. It will afford us pleasure to act as arbitrators if both will agree to abide by our decision.

EDINBURGH STUDENT.—The book is in our to-day's list of "New Books and New Editions," published in another column. We cannot answer your query until we have read the book. In any case you cannot do wrong in taking Monro's "Manual of Medicine" as a very safe and practical guide.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, NOVEMBER 7th.

OBSTETRICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8 p.m.: Specimens will be shown by Dr. C. H. Roberts, Dr. Handfield-Jones, and Dr. H. R. Andrews. Short communications:—Mr. A. Doran: Myomectomy during Pregnancy and Labour at Term in an Elderly Primipara, with Notes on Similar Cases. Paper:—Dr. W. R. Pollock: The Present Position of External Version in Obstetrics with a Suggestion of a New Method of Performing it.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. M. Collier: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. G. A. Sutherland: Vomiting in Children.

THURSDAY, NOVEMBER 8th.

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Titchborne Street, Edgware Road, W.).—8.30 p.m.: Papers:—Dr. H. Spencer: On the Treatment of Extra-uterine Pregnancy.—Dr. W. Harris: The Causation and Treatment of Some Headaches.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street, Cavendish Square, W.).—8 p.m.: Card Specimens. 8.45 p.m.: Special Meeting to Discuss the Advisability of Joining in the Proposed Union of the London Medical Societies.

BRITISH GYNÆCOLOGICAL SOCIETY (20 Hanover Square, W.).—8 p.m.: Specimens will be shown by Dr. J. H. Swanton and Mr. J. F. Jordan. Papers:—Dr. J. H. Swanton: Note on a Specimen of Cystoma of Ovary with Thyroid Tissue Present. Dr. Aarons: Notes on the Medical Treatment of Uterine Hæmorrhage.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m.: Lecture:—Dr. J. F. H. Broadbent: Aortic Regurgitation in Later Life.

FRIDAY, NOVEMBER 9th.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8.30 p.m.: Papers:—Dr. E. Diver: A Principle of Treatment Suggested for Some Untoward Fractures, especially of the Femur. Mr. C. Symonds: Multiple Strictures of the Ileum, Resection, Recovery. Mr. E. M. Corner: Rotatory Subluxation of the Atlas. Mr. J. Clarke: Case of Congenital Deformity of the Spine.

MEDICAL GRADUATES COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.:—Mr. W. Dodd. Clinique. (Eye.)

Vacancies.

Gloucester County Asylums.—Junior Assistant Medical Officer. Salary £150 per annum, with board, apartments, and washing. Applications to the Medical Superintendent.

County Asylum, Dorchester.—Junior Assistant Medical Officer. Salary £140 per annum, with board, lodging, &c. Applications to the Medical Superintendent.

Derbyshire Royal Infirmary.—Superintendent and Secretary. Salary £300 per annum. Applications to Walter G. Carnt, Secretary-Superintendent, Royal Infirmary, Derby.

Nottingham City Asylum.—Junior Assistant Medical Officer. Salary £150 per annum, with apartments, board, &c. Applications to the Medical Superintendent.

Sheffield Royal Infirmary.—Secretary. Salary £400 per annum. Applications to the Chairman at the Infirmary.

Liverpool Hospital for Consumption and Diseases of the Chest.—Pathologist and Assistant to the Honorary Medical Staff. Salary £150 per annum. Applications to Alfred Shawfield, Secretary, 77A, Lord Street, Liverpool.

Staffordshire County Asylum, Cheddleton, Leek.—Junior Assistant Medical Officer. Salary £150 per annum, together with board, furnished quarters, and washing. Applications to the Medical Superintendent.

Barnsley Hall Asylum, Bromsgrove, Worcestershire.—Senior Assistant Medical Officer and Deputy Medical Superintendent. Salary £200 per annum, with furnished quarters, board, washing, and attendance. Applications to the Medical Superintendent.

Richmond District Asylum, Dublin.—Clinical Assistant. Salary £80 per annum, with furnished apartments, &c. Applications to Conolly Norman, Medical Superintendent. (See advt.)

Appointments.

BOND, B. M., M.R.C.S., L.R.C.P.Lond., Certifying Surgeon under the Factory and Workshop Act for the Fulham and Hammersmith District of the county of London.

CURRIE, J., M.B., M.S.Edin., Certifying Surgeon under the Factory and Workshop Act for the Lees District of the county of Lancaster.

ENGLISH, HOWARD, Resident Surgeon to Richmond, Whitworth, and Hardwicke Hospitals.

HAWKINS, ARTHUR, M.R.C.S., L.R.C.P., House Physician at the Royal Devon and Exeter Hospital, Exeter.

NESBITT, G. E., Resident Physician to Richmond, Whitworth, and Hardwicke Hospitals.

RENTON, JAMES M., M.B., Ch.B.Glasg., House Surgeon at the Tottenham Hospital, London, N.

SINIGAR, H., M.D.Lond., Certifying Surgeon under the Factory and Workshop Act for the Southall District of the county of Middlesex.

TURNER, G. G., M.B., M.S.Durh., F.R.C.S.Eng., Honorary Assistant Surgeon to the Royal Victoria Infirmary, Newcastle-upon-Tyne.

Births.

CRAWFORD.—On Oct. 25th, at Palmerston, Swanley, Kent, the wife of J. Dawson Crawford, M.D., of a son.

ROBINSON.—On Oct. 30th, at the Grange, Blechingley, Surrey, the wife of C. A. Robinson, B.A., M.B., B.C.Cantab., of a son.

Marriage.

MALLINSON—SCOTT.—On Nov. 1st, at St. Margaret's Church, Ilkley, Arthur William, elder son of the late William Arthur Mallinson, Leeds and Ilkley, to Helen Brown, youngest daughter of Thomas Scott, M.D., Ilkley.

Deaths.

CLARKE.—On Nov. 3rd, at Bournemouth, Benjamin Clarke, F.R.C.S., L.R.C.P., late of Upper Clapton, in his 86th year.

ELLIS.—On Nov. 3rd, at Balmoral, Bournemouth, Heber Dowling Ellis, M.D., in his 67th year.

MAIN.—On Nov. 1st, at 24 Alexandra Villas, Finsbury Park, London, Joanna, wife of Robert Main, M.D.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIII. WEDNESDAY, NOVEMBER 14, 1906. No. 20

NOTES AND COMMENTS.

The Amalgamation of London Medical Societies.

WE are glad to learn that the amalgamation of the Gynæcological and the Obstetrical Society has almost become *un fait accompli*. At the present moment a report, dealing with the main outlines of the project, has been adopted by a Joint Committee of the two Associations, and has also been adopted by the Council of the Obstetrical Society. It has now to be brought before a general meeting of each Association, and, if it is passed by them, it will be finally ratified by a joint general meeting. We have been strongly in favour of such an amalgamation, and congratulate the Associations on having successfully bridged over the many difficulties. Not alone in London will the union be an advantage to obstetricians and gynæcologists, but also throughout the country. We shall be greatly surprised if the first result is not an immediate influx of new members.

The Ophthalmological Society declines with thanks.

THE Ophthalmological Society of London, however, hold a different view. On the 10th inst. a special meeting was held to consider the question of amalgamation. Lo and behold! the whole meeting, *una voce*, declared dead against the scheme. Not a single vote was recorded on the other side. So that one leading London society, at any rate, has declined to merge its identity in an amalgamation scheme. The result is one of significance, and emphatically demonstrates that the scheme will be anything but universal.

Sidelight on Medical Education.

SINCE the publication of an article on this subject in our last issue, our contemporary the *British Medical Journal* has published a letter from Professor Francis Dixon in which he takes very grave exceptions to the comments made by our contemporary, and requests that the latter will either withdraw its statements or justify them by republishing the tables in question together with his remarks upon them. The reply vouchsafed to him is flippant in the extreme, and does not appear to us to be either dictated by the spirit proper to the occasion or couched in dignified language. "We are sorry to have annoyed Professor Dixon," runs the editorial note, "who, indeed, has our entire sympathy, for it is always annoying to be misunderstood, and we are suffering in the same way." And then a little further on it continues, "for the sake of our space and for his satisfaction we will gracefully allow him to assume that the rest of his strictures and observations are justified." Such heavy wit is singularly out of place in dealing with a matter which is capable of the plainest proof. If Dr. Dixon is wrong our contemporary should clearly say so and prove its statement. If, on the other hand, he is right, our contemporary, we are sure unintentionally, has made a statement injurious to the reputation of Irish medical bodies, and in such a case one would have expected a more gracefully worded apology.

Testimonials to Nurses.

DR. J. B. NEAL, Medical Superintendent of Wandsworth Infirmary, is much to be congratulated on emerging scathless from the law-courts last week. A male nurse who had left the Infirmary with a good character, gave Dr. Neal's name as a reference to a gentleman who proposed to engage him. Dr. Neal, confusing the man with another attendant, said that he had had mental trouble through an accident. This unfortunate mistake was made the subject of an action by the attendant, who contended that malice towards him had been shown by Dr. Neal. There was no doubt about the mistake and the case might have gone badly for the defendant if the judge had not taken the common-sense view that the occasion was privileged. At the same time, even privilege must have its limitations, and the defendant probably could not have come much nearer the partition. Though there was not the slightest suspicion of malice in his statement he will probably exercise more caution in future in discharging so responsible a duty as a referee to a man's character.

Herbalist and Arson.

A SCAMP who had the impertinence to describe himself as a "professor and a doctor" was tried at Lancaster Assizes on November 8th. This "professor" kept a shop, as is usual with "professors" of a certain type, and he seems to have belonged to that peculiar people, the "herbalists." Herbalising apparently did not flourish with this particular professor, for he, after insuring his shop for £400, was seen by a witness deliberately to attempt to burn it down at night. Only £8 worth of damage was actually done. The Fire Company not only did not pay this, but they actually initiated a prosecution. The jury took a lenient view, and only convicted the "professor" of attempted

arson, and the judge gave him eighteen months' imprisonment. When will the press stop heading paragraphs of this sort, 'Doctor' convicted of Arson" ?

LEADING ARTICLE.

THE GENERAL MEDICAL COUNCIL ELECTIONS.

THE advent of another election of direct representatives of the profession to the General Medical Council is arousing more than ordinary interest. There are various explanations for this alertness, and among them it seems not unreasonable to attribute some influence, at any rate, to the awakening of the general practitioner. There can be little question that the times are out of joint for the rank and file of the medical profession. The stress of competition of all kinds has fallen with such crushing effect that it is no longer possible to maintain the average professional income. Under these cricumstances, as pointed out in the letter of a correspondent published elsewhere in our present issue, it behoves us to be calm and philosophical in our discussion of the present issue. His views are strongly and concisely stated, and in the main reflect those that have been from time to time advocated in the MEDICAL PRESS AND CIRCULAR. He points out that the addresses of the candidates are notable for the absence of enthusiasm for reform, a feature that is admirably illustrated by the fact that only one candidate accepts the whole Bill drawn up by the British Medical Association. With his remark that the demand for the increase of the number of direct representatives "goes to the heart of things," we heartily agree. The General Medical Council is not a representative body, and until it is reconstituted upon lines of popular franchise, the general practitioner will be left wandering in the wilderness. The present haphazard control of the medical profession is rendered worthless and irritating in the absence of any protection against irregular competition. What encouragement is there to an honourable man to practice his profession on lines of the highest morality, when he cannot pay his rent and his tradesmen's bills, while at the same time the bread is taken out of his mouth by quackery of every kind. The General Medical Council is composed of men who have the interests of close corporations to defend, and who are absolutely out of touch with the general practitioner. When any attempt is made to increase the number of direct representatives, the Council meet the suggestion with a sanctimonious *non possumus*. Not long ago, however, the learned President of that body admitted that the Council had in various directions made a law unto themselves. Why should they evade so obviously just and reasonable a demand as the increased representation of the medical profession. If they had no fear of the democratic element, it is safe to assert that the direct representatives would long ago have been added to. So vital is this point that there is no great need to discuss side issues in this or any other Council Election. Should the medical profession ever establish a complete and adequate organisation, the game will speedily fall into their hands. They have the overwhelming power of the boycott, and in a few months the whole of the classes who control the Council as nominees of close corporations could be reduced to reason. Undesirable as it would be to raise an internecine strife, it is nevertheless to be feared that sooner or later the matter will be settled by a sharp and decisive conflict. The General Medical Council, like the House of Lords, is practically an irresponsible body. The presence of a faint leaven of elected members is much as though the Lords permitted a dozen representatives of the people to their benches. There is one way in which a death struggle may be averted, namely, by a gradual substitution of popular election for that of nomination of the representatives of the various medical corporations. Why, for instance, should the members of the Royal College of Surgeons of London be disfranchised in a matter of such vital importance as their representation on the only body that has the smallest chance of protecting or advancing their material interests ? Why should the Scotch licentiates be refused a voice in the election of the gentlemen who represent the ancient colleges of Edinburgh and Glasgow ? The only defence is that of privilege, and of class government. The General Medical Council is an autocratic and irresponsible non-elected body made up for the most part of representatives of corporations that are no less irresponsible and hopelessly out of touch with the spirit of the times. When the general practitioner really asserts himself, one of his first demands will be a share in the control of his own colleges, and a voice in the election of his college representatives. Meanwhile, it is the duty of every voter to make up his mind clearly as to what pledges he wants from the candidate to whom he is willing to give his support.

NOTES ON CURRENT TOPICS.

Food and Dirt.

AT a recent meeting of the National Health Society, Sir Frederick Treves and Sir James Crichton-Browne made merry over the carelessness of the public with regard to its food supply. The former drew an amusing comparison between the habits of prehistoric man and those of his modern descendant in their manner of dealing with food, and the advantage did not rest with the product of civilisation. Both, Sir Frederick pointed out, carried meat on their bare heads, both deposited it on dirty floors, and both exposed it to the dust and dirt of the atmosphere. But the neolithic man at least saw his meat killed, which is more than modern man takes the trouble to do. Sir James Crichton-Browne, who followed, brought up "The Jungle" stories again, and referred to them with horror, denying that the panic

created had done any harm. Whatever may or may not be said about the author of that novel, if he has directed people in every country to pry into and reform their methods of food production and transit, he will have done some good by his tirade. The apathy of the public mind in this matter was illustrated by Sir James by mentioning that an outbreak of typhoid in West Ham has just been caused by the consumption of cockles from the same polluted creek which caused an outbreak at Southend four years ago. Truly there is little exaggeration about the saying that people in their lifetime have to eat a peck of dirt.

The Soap Trust and Health.

At the present moment, when the efforts of certain soap manufacturers to combine is being resisted tooth and nail by consumers, it is well to note that soap is not only a detergent instrument, but a great moral force. The object of trusts and combines is either to lower working expenses or to raise prices; in most cases it is both, and therefore the interest of the organisation is always against the public. In matters of luxury there is no need for us to say anything, but in matters affecting the public health and morals so intimately as does soap, it is of the utmost importance that medical opinion should make itself heard. The need of the moment is to realise that the day of the antiseptic has passed, and the clearer dawn of asepsis, which is cleanliness, has broken. Lister showed that wounds suppurated because of bacterial contamination, and he used antiseptics as curative agents. The modern development of Lister's doctrine is the prevention of contamination by scrupulous cleanliness, not only in the care of wounds, but in that of everything around us. To this end soap is a prime necessity, and it is not going too far to say that cheap soap is one of the most important requisites of hygiene. Anything that raises the price or lowers the weight of a pound of soap has the unsparing condemnation of the medical profession.

Discharge of Army "Incurables" from Netley.

The recent announcement by Mr. Haldane that a number of incurables were to be discharged from Netley has naturally excited a good deal of public interest. There is no particular political aspect involved, inasmuch as the present Liberal War Minister is simply carrying out the policy of his Conservative predecessor. So far as the moral obligations of the nation towards its soldiers are concerned, however, a point of considerable importance is involved. Many a soldier who has fought bravely for his country dies in a workhouse. Many of those who endured wounds, disease, and hardship in South Africa have drifted into unemployment, crime, and the workhouse. It is not apparent why the private should not be pensioned for life as well as the superior officer. The discharges mentioned by Mr. Haldane, however, if we understand the matter aright, apply to sufferers from intractable syphilis. The stern moralist would naturally advance strong arguments against helping a man bear the punishment of his own sensuality. On the other hand, it may be urged that if cured syphilis confers no disability, why should the unhappy man disabled by uncured syphilis pay the further additional penalty of loss of pension? Further, the soldier is an unmarried man, in nine cases out of ten, by the regulations of the service. The moralist will do well to turn his earnest attention towards increas ing the marriage facilities granted to our troops.

A State Medical Service for Ireland—Important Announcement.

A special General Meeting of the Irish Medical Association will be held to-day at 2 p.m. at the Royal College of Surgeons to consider the action which the Association should take with regard to the Report of the Poor-law Commission just issued. In addition, the proposal to convert the Irish Poor-law Service into a State Medical Service will come up for consideration. We urge on those of our readers who are members of the Association to make it their business to attend the meeting, as the decision to be arrived at will be fraught with the greatest importance to the medical profession in Ireland. Medical men will do well to remember that should a State Service be adopted, the rights of all existing medical officers will be fully conserved and in addition they will receive the benefit of such increase in salary as may be decided upon. They will also become entitled to a pension as of right. It is obvious that the proposal will be strenuously resisted in some quarters, and medical men who desire to keep an open mind will do well to insist that those who advise opposition to it should give very definite reasons for their advice. Poor-law medical officers have now before them a definite opportunity of obtaining the reforms for which they have so long pressed, and if they deliberately cast it on one side, they will find it difficult in future to obtain that practical sympathy to which the present condition of the Poor-law Service entitles them.

Anti-Vivisection Tactics.

The methods that are being used by certain anti-vivisectionists to cast slurs on the Royal Commission sitting to enquire into experiments on animals deserve to be carefully noted. Their first step was to attempt to discredit the Commission by complaints against its *personnel*, which were finally reduced to absurdity, seeing the ample representation given to anti-vivisectionists, by the complaint that there was no "expert anti-vivisectionist" to voice their claims. The next step was loudly to cry out against the determination of the Commission to sit *in camera*. Now this decision, which was arrived at by resolution of the Commission, and had nothing whatever to do with the Government, was come to for the simple reason that the room in which sittings are to take place is too small to hold anybody beyond the Commissioners and witnesses, and even they are crowded. Of course, all evidence offered will

be received, and the proceedings published in full at the end of the sittings. The next unworthy step was to supply the press with sensational articles suggesting that certain disgusting horrors were being concealed from public notice. An article appeared in the *Daily Mirror* of November 6th, describing in vivid language certain acts alleged to have been carried out by French experimenters, with the comment: "The class of evidence which will be discussed at this private conference (*i.e.* the Royal Commission) is intensely interesting to the British public. It is represented by this typical statement . . ." Moreover, a bogus report of evidence alleged to have been given by Professor Thane, Inspector under the Vivisection Act, was sent round to the papers, and published at least by one of them in good faith. This report was contradicted authoritatively the next day. It is by actions of this sort that the disgust of fair-minded people is aroused.

A Striking Experiment in Infantile Mortality.

THE Mayor of Huddersfield, in resigning office last week, was able to put on record an experiment which deserves to rank high as a distinguished service to the community. While others were content to wring their hands and moan despairingly over the vast infantile mortality, Alderman Benjamin Broadbent, of Huddersfield, tackled the problem on first principles. Two years ago, on assuming office as Mayor, he offered £1 to the parents of each child born during his mayoralty who attained the age of twelve months. The main feature of the experiment was to see if by constant watchfulness and helpfulness on the part of a small band of voluntary lady workers any appreciable reduction could be effected in the infantile mortality rate of Longwood. The previous ten-yearly average in Huddersfield had been 139, and that of Longwood 122. The actual figures will be found in our medical news column, but the broad result is that, taking the most adverse view, the infantile mortality has been reduced to less than half the average rate Alderman Broadbent may be congratulated upon having made one of the most remarkable experiments ever attempted in public health administration. The reduction of the preventable margin fully justifies his own epithet "astounding." Henceforth there can be no more excuse for communities that tolerate this yearly death-toll of the "innocents," inasmuch as this enterprising Yorkshire Mayor has proved to demonstration that for the most part the sacrifice is preventable and has been prevented.

When Analysts Differ.

IT says much for the capabilities of medical men that so many of the accusations brought against them are based on trivial details. Persons connected with the lay press are too often accustomed to constitute themselves censors regarding scientific matters, and although their ignorance may be evident to the profession, their misleading headlines often seriously lower the prestige of their victim among his clients. The Public Analyst for Dorset, Dr. Comyns Leach, recently reported a sample of milk taken under the Food and Drugs Acts as containing 2.70 per cent. of fat. Somerset House, to whom the reserve sample was submitted two months after being taken, found the percentage of fat to be 2.77. The Government Analysts use methods for the estimation of fat which are different from those usually employed by Public Analysts, and taking that fact into consideration, together with the long period that elapsed between the two analyses, the difference is practically nil. The case was dismissed. Yet, in spite of that circumstance, the editor of the *Western Gazette* apparently felt justified in adopting as a headline: "Singular Case at Portland, Analysts Disagree!" Did he but appreciate the difficulty of analysing sour milk and the experimental errors of milk analysis, he would perhaps perceive the ridiculous character of his heading, and would not have thus inferred incapacity on the part of the medical man who acts as County Analyst. It should be remembered that when discrepancies occur in analysis, the Government is invariably credited with giving the correct figure, while the Public Analyst, who has had the advantage of analysing the milk while fresh, is gratuitously assumed to be wrong.

Colwyn Bay Murder Trial.

AN unusually interesting medico-legal case was decided at Ruthvin Assizes on November 1st. A servant girl was indicted for the murder of her newly-born child, and extraordinary facts came to light during the hearing. It seems that the child was born while she was straining at stool in an outdoor privy, and a fellow-servant later found he holding the child's leg in one hand and a hatchet in the other, while she hacked wildly at the pan of the closet. The subsequent history was not quite clear, but they both had tea together, the mother saying the child's body was on the dust-heap. The Treasury put forward the view that the girl had murdered the child with the hatchet, because not only did they have the fellow-servant's evidence, but the child itself was much cut about, and its head was separated from the body. Two medical witnesses were called and testified that severance with a sharp instrument was the only possible explanation of the condition of the body, and that the child had had a separate existence. The view put forward by the defence was that the child's head had been stuck in the pan, and that the mother had dragged the body away from the head in her endeavours to save him, the hatchet being used to cut away the pan. Three medical witnesses were emphatic that the head had been torn off and not hacked off, and threw grave doubt on the evidence that the child had actually lived. Eventually the jury found the girl not guilty, as indeed they were bound to do on the evidence. The case created great interest, and the usual sneering remark about the differences of doctors were freely made.

Exit "Capsuloids."

The quacks, as might be expected, make much capital out of baldness and its "treatment." They are always quick to seize upon the frailties of mankind, one of which is a little pardonable vanity in the matter of his growth of hair. Baldness they proceed to attack by a host of remedies, external and internal. It has been pointed out again and again in these columns that no internal remedy is known that will consistently induce a growth of hair. In spite of that fact, various nostrums of the kind are sold to the public on the pretence that they will cure baldness. Were such a remedy known, it would be welcomed with open arms by the medical profession, which is always eager to remedy the infirmities of mankind. For some time past extravagant claims have been advanced as to the effect of an internal remedy upon the growth of hair. The company has been brought to a standstill by a verdict in the High Court, declaring the name "Capsuloids" to be an infringement on Messrs. Burroughs and Wellcome's trade-mark, "Tabloids." It forms a scathing commentary on the quack medicine trade to learn in the course of this trial that upwards of £1,000 a month had been spent in advertising a preparation for the claims of which it is impossible to find any reasonable scientific ground.

The Tenure of Post-Office Surgeoncies.

Recently the attention of the House of Commons was called to the age-limit of sixty which the Postmaster-General proposes to impose upon all medical appointments in his department. It is clear that the sudden imposition of such a condition of tenure must inflict a certain amount of hardship upon existing holders of such appointments. There are obviously sound reasons for establishing some general rule with regard to age in relation to efficiency. A rigid imposition of any age limit, however, would rob the State of many valuable servants, not only in the Post Office, but in every other branch of the public service, paid or unpaid. If a man be unfitted to perform the duties of a medical officer at sixty, he is hardly likely to discharge more efficiently those of a general officer, of a judge, or of a cabinet minister. Yet a man is considered a young man in politics at fifty; prime ministers are often seventy to eighty years of age; generals conduct active campaigns at seventy, judges sit at eighty. Why, then, should inoffensive post office surgeons be turned out at sixty? Much the same line of reasoning applies to honorary medical appointments at lay hospitals. In any case, if a new rule is to be applied it would obviously be more just not to make it retrospective in its first application.

PERSONAL.

Sir Alfred Downing Fripp, C.V.O., C.B., has been created Knight Commander of the Royal Victorian Order.

Upon William Maurice Abbott Anderson, M.B., has been conferred a membership of the fourth class of the Royal Victorian Order.

Dr. D. K. McDowell, C.M.G., Principal Civil Medical Officer Straits Settlements, leaves England on the 23rd inst. for Singapore to resume duty after a lengthy leave of absence.

A knighthood has been bestowed upon Dr. Charles F. Hutchinson, who during the last Parliament was returned for the Rye Division of Sussex. Sir Charles is a Liberal in politics.

One of the most popular of the birthday honours will probably be that of Professor John W. Byers, who has held the chair of midwifery and diseases of women at Queen's College, Belfast, since the year 1893.

The well-deserved honour of knight bachelorhood has been conferred by His Majesty upon Professor Rupert William Boyce, M.B., F.R.S., Dean of the Incorporated Liverpool School of Tropical Medicine.

Among the birthday honours, Mr. John Tweedy, President of the Royal College of Surgeons, London, has received the honour of knighthood. Mr. Tweedy has long been connected with University College as Surgeon and Opthalmic Surgeon.

Another Royal recognition that will be popular amongst medical circles is the C.M.G. bestowed upon Mr. Petro James Michelli, the well-known secretary of the Seamen's Hospital Society, in connection with his services to the London School of Tropical Medicine.

At the annual general Court of Governors of Guy's Hospital, Prince Francis of Teck and Messrs. Otto Beit and Waldorf Astor were elected to the corporation to fill vacancies caused by the deaths of the Earl of Leven and Melville, Mr. Rodolph Hankey, and Mr. Alfred Beit.

Mr. Edmund Owen, F.R.C.S., Consulting Surgeon to St. Mary's Hospital, Paddington, and to the Great Ormond Street Hospital for Sick Children, has been nominated by the Council of the Royal College of Surgeons, England, to deliver the Bradshaw Lecture, on December 12th, the subject of which will be "Cancer: Its Treatment by Modern Methods."

A Companionship of St. Michael and St. George has been conferred upon Sydney Wilson Thompstone, F.R.C.S., in recognition of distinguished services as principal medical officer in Northern Nigeria. A similar distinction has been bestowed upon Wilfred T. Grenfell, M.R.C.S., Superintendent of the Royal National Mission to Deep Sea Fishermen.

The President of the Board of Education on the 13th inst. received a deputation urging the necessity of teaching hygiene and temperance in schools. Amongst the deputation introduced by Sir Thomas Barlow were Sir T. Lauder Brunton, Dr. John Robertson, Dr. James Niven, Miss Alice Ravenhill, Dr. James Macdonald, Dr. Langley Brown, Dr. Clifford Allbutt, Sir Victor Horsley, and Dr. G. A. Heron.

Sir Victor Horsley, who has been connected with University College as a student and as a teacher for 30 years, has resigned his Professorship of Clinical Surgery and Surgeoncy to the hospital on account of increasing duties. The Council adopted unanimously the following resolution:—"That the Council, having received with great regret Sir Victor Horsley's resignation of his Professorship of Clinical Surgery and his position of Surgeon to University College Hospital, whereby his official connection with the College is severed, desire to put on record their recognition of his long service to the College and the distinction he has conferred upon it by his eminence as a scientific investigator."

A CLINICAL LECTURE
ON
ERYTHEMA INDURATUM (BAZIN). (a)

By J. MAGEE FINNY, M.D.,

President, Royal Academy of Medicine in Ireland; King's Professor of Practice of Medicine.

GENTLEMEN,—You have been watching a case with me during the last week or two, and although it may not have appealed to your imagination, nor called upon your clinical acumen and resources, in the same way, and to the same extent, as cases of heart disease or nervous disorders have done, yet a little retrospect of the notes of the case cannot, I think, fail to show you that it is not lacking in pathological and clinical interest, and that it presents features and peculiarities well worthy of your investigation and consideration.

First of all, the disease which the following case illustrates is by no means frequently met with in Great Britain and Ireland, although it was spoken of as not uncommon in France by Bazin, who first described it. Possibly it may have been overlooked or confounded with other complaints. Then again the name of *Erythema Induratum* is misleading, as it has hardly any feature in common with any one of the many manifestations of the hydra-headed *Erythema multiforme.*

The principal features of the disease will be observed in the following notes of the case, taken by my clinical clerk, Mr. Gregg.

Case.—Maggie F., æt. 18, domestic servant, was admitted to Sir Patrick Dun's Hospital on March 27, 1906, on the recommendation of my friend, Mr. Albert Croly, F.R.C.S.I., complaining of swelling and of pains in her legs. About the beginning of February last she noticed reddish lumps making their appearance on her legs, on the inside of the calf and the parts below it, and, later on, others appeared on her arms. For the past three or four years, she states, she has had similar attacks each spring, but none so severe as the present one, and the discomfort and swelling of her legs, and the fear that some of the nodules would break, compelled her to give up her situation and seek medical aid. Patient is a robust, healthy-looking girl, well developed and fat, with a clear bright complexion, dark hair and good teeth, and weighs 11 stones. She does not remember having ever suffered from any serious illness other than the present, except that she is very liable to colds in her throat and swellings of the glands of her neck. On either side of the neck in the posterior and supra-clavicular triangles, around the lower jaw, and under the chin, a number of lymphatic glands may be felt enlarged, and those near the ramus show up as distinct swellings. They are freely movable and painless. The patient states they have been swollen for a number of years past, and that when she has a cold they swell up much more and cause loss of voice. Enlarged glands cannot be found elsewhere.

Careful examination failed to discover any disease or perverted function of any organ in the body other than the glands in the neck, and that menstruation, though regular, is very scanty, and lasts only half a day. On admission the legs were swollen about the ankles and pitted on pressure over the tibiæ. At the back and chiefly the inner sides of the leg, below the calf, a number of pale purplish-red swellings or nodules could be seen and felt, some the size of a small nut and others as large as a cherry or walnut, and while some were separate, others seemed to coalesce and became fused into hard irregular masses 1½ in. long by ½ in. wide, somewhat doughy to the feel. More lumps were to be made out by palpation than could be seen, and they lay deeper than in the skin. There were no nodules or swellings present over the front of the tibiæ. At first sight the œdematous legs, the discolorations, and the lumpy condition gave the idea that it was a case of varicose veins, but there were no veins visible in the calf or beside or behind the knees. There was no broken or suppurating nodule, though a few near the surface were soft and elastic, and gave the impression that they contained fluid. A similar state of nodules, though very much less numerous, was found in the upper extremities. In the upper third of the arm five or six bluish swellings, like small marbles, could be felt in the skin and under it, on the outer and back part over the insertion of the deltoid, and over the triceps. They were barely visible, but were distinct to handling. They were confined to the regions mentioned, and were not present in the forearms or over the ulnar surfaces. The nodules were not painful in the arms, and the discomfort complained of in the legs was rather due to the swelling and stiffness than the actual pain of the nodules. However, two or three were sensitive to the handling, and a tight bandage gave discomfort.

The treatment was simple and, fortunately, very successful. The girl was kept in her bed (the lower part of which was raised on blocks) for ten days; the bowels were well opened every few days with an aloes pill, At first sodium salicylate was given for five days, and then quinine sulphate was substituted.

The legs were gently rubbed in an upward direction, and a Domette bandage applied. In a week's time the larger indurations became much smaller and the colour of the nodules changed from violet-red to a more natural hue. At the end of the second week she was allowed up, wearing the bandages, and left the hospital the week afterward, to go to her home situated in good air high up in the Dublin mountains, promising to return to have the glands in the neck removed. It was very fortunate that the nodules disappeared by absorption, and that none of them had ulcerated, as usually the ulcers caused by necrosis are very indolent. In July she entered hospital a second time with a

(a) A Clinical Lecture delivered in Sir Patrick Dun's Hospital.

view to removal of the glands from her neck. Dr. Arthur Ball kindly took her into his charge, but he decided not to operate, as the glands gave her no trouble since March and were smaller. The legs and arms were quite free from all nodules, and there was no sign of swelling or discoloration above the ankles in the situation where the nodules had been.

The Pathology of Erythema Induratum is not conclusively determined.

There are two well-defined types, according to Whitfield (*Brit. Journ. of Dermatology*, August, 1905), the tuberculous and the non-tuberculous. The latter occurs in older patients, and runs a more rapid course, showing less tendency to ulcerate and causing less pain. The former, or the tuberculous type, is that to which I call your attention, and of which this patient is an example. From the frequency of the association of the cutaneous affection with tubercle, Bazin's disease is sometimes called *E. induratum scrofulosorum*, and Dr. Payne describes a case under this designation in the *Trans. Dermatological Soc.*, Vol. I., page 79. Opinions therefore differ as to the true pathology of the affection. Some consider it is but a rare variety of *E. Nodosum*, and deny it has any relation to tubercle; others, again, look upon it to be a cutaneous manifestation of tuberculous infection, and experimental inoculation has succeeded in producing general tuberculosis, although the bacillus has never been found. In 1905 Harttung and Alexander, (*a*) summarising a histological examination of five cases, state their belief that *E. Induratum* is a tuberculous affection of the skin of a hæmatogenous origin, and essentially an arterial and embolic condition.

Perhaps the chief interest of *E. Induratum* lies in its diagnosis, as it resembles E. Nodosum, syphilitic gummata, and phlebitic thrombosis.

From E. Nodosum, with which you are familiar, it may be distinguished by the following:—

(1) The situation of the nodules being in the soft parts in the back and sides of the leg below the calf, and their absence from the anterior and tibial aspects;

(2) The absence of the great blush and the painful bruise-like swellings common to E. Nodosum;

(3) The absence of all febrile symptoms and arthritic pains;

(4) The indolent course of E. Induratum with many relapses;

(5) It not uncommonly presents necrotic ulcerations which are very slow to heal up.

The fact that this young patient is a female, and scrofulous, while it strongly points to the tuberculous nature of the nodules and to "Bazin's disease," is not however sufficient to exclude *E. Nodosum*, as that disease is so often present in young women of her age and station in life. The occurrence of nodules in the upper arms is rare in E. Induratum, although a few cases are on record of such an extension; and Galloway (quoted by Crocker) gives a case in which nodules were present in all the limbs, shoulders and ankles. In E. Nodosum nodes in the upper extremities are a complication not very unusual, but it struck me as a remarkable aid to diagnosis that the situation of the nodules in this case was in the upper third of the arms and not in the forearms over the ulnar aspect, as we see it in E. Nodosum.

The diagnosis from syphilitic gummata hardly arose in this case, as it is in the ulcerative stage that the resemblance exists between the two affections. The age, history, cachexia will assist. Moreover, gummata are rarely present in the legs, they are few in number, and when they break down the ulcers occur rapidly, are sharply circumscribed, and covered with a purulent discharge, whereas in E. Induratum the process is slow and is one of necrosis.

The diagnosis from phlebitic thickening or thrombosis was readily made out in the absence of the symptoms characteristic of these conditions, and as no varicose veins were to be felt or seen in the usual situations, and, although the feel of the nodules and masses was somewhat like that of the thrombosed veins their colour, shape and course were sufficiently different to prevent a mistake.

(*a*) "Archiv. für Dermat. und Syph.," "Med. Annual," p. 206, 1906.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The Lecture for next week will be by Dr. G. Edelssen, Professor of Surgery in the University of Hamburg (specially reported by our own correspondent) on "The Medicinal and Dietetic Treatment of Catarrhs of the Bladder and Kidneys."*

ORIGINAL PAPERS.

SOME NOTES ON FAMILY DISEASES. (*a*)

By T. K. MONRO, M.A., M.D., F.F.P.S.G.,

Physician to the Glasgow Royal Infirmary, and Professor of Medicine in St. Mungo's College.

(Concluded.)

The doctrine of premature decay was long ago applied in one form or another to explain the onset of some of the most common diseases. Thus in the case of cancer no satisfactory theory has yet been devised; different theories seem to suit different cases. But it has been supposed that each tissue is to a certain extent controlled as regards its powers of multiplication by the other tissues which happen to be its neighbours. Thus in the case of a muscle, when the muscular fibres waste, the interstitial tissue tends to increase, and a similar change takes place when nerve tracts degenerate. So when cancer develops in the tongue or stomach, the overgrowth of epithelium has been attributed to diminished opposing power of the sub-epithelial tissues. This obviously is a very partial explanation, but experience suggests that the connective tissues are most vigorous in early life, the period when sarcoma is most common, and that they become senile after 40 or 45. They can then be easily invaded by the epithelial elements, which retain much of their vigour till twenty years later in the life of the individual man or woman. Cancer is well known as a family and hereditary disease; as in the case of Napoleon the First, who, like his brother and two of his sisters, as well as his father, died of cancer of the stomach.

I remember the day when phthisis pulmonalis—consumption or wasting of the body, associated with disease of the lungs—was regarded as a decline of the body generally, in which the lungs were the first part to show distinct signs of disintegration. Hereditary tendency was one of the principal causes recognised at the time, just as infection is now. Both factors are of importance, the soil and the seed. I

(*a*) Presidential address delivered to the Glasgow Southern Medical Society on October 4th, 1906. Illustrative cases and photographs were exhibited.

recently examined a man of 44, who had been suffering from phthisis for 2½ years. "All the family," he remarked, "died of consumption"; his father at 45, his mother at 42 or 45, his sister at 35, his two brothers at 20 and 16, and also two maternal aunts. One might be disposed to say that this was a clear case of infection. But the man left Britain at the age of 18, 26 years ago, and did not return till a couple of months ago, or more than two years after he became ill. His people remained here all along. He had malarial fever 20 years before the present illness, but thereafter he enjoyed very good health till about 2½ years ago. His parents died of phthisis in their fifth decade, and here he is at the same age with the same disease. The inference appears to be that in this family the resisting power of the lungs to tuberculosis was below normal, and perhaps also that it diminished further in the two decades following the completion of adolescence.

It will be seen that several kinds of disease are almost necessarily mingled in any list such as that which I have brought before you:—

(1) There are *family diseases* in the strict sense of the expression; diseases which occur among the members of one family, brothers or sisters, or both, in one generation. These are the primary subject of this paper, and are best represented by the premature degenerations of which I have spoken. They involve certain groups of muscles, certain systems of nerve-cells and fibres, the skin or the retina. The tissues in question are apparently normal at birth and for some time afterwards, but they decay before the rest of the body decays, and often before the rest of the body has reached maturity. Muscular dystrophy, Friedreich's disease, and retinitis pigmentosa belong to this category.

(2) There are *hereditary diseases*, not in the sense in which we speak of inherited syphilis, where an infection is derived by an infant from its parent, but in the sense that they are due to a tendency to developmental defect which is passed on from one generation to another.

The first and second classes are scarcely separable from one another in practice, since so many of their members belong to both. Nevertheless, several diseases or abnormalities which have been mentioned (*e.g.*, xeroderma pigmentosa) show the family tendency very strongly and the hereditary tendency but feebly.

The congenital deafness which leads to mutism is also much more a family than a hereditary affection.

(3) There are *congenital abnormalities of structure* (coloboma iridis, harelip, supernumerary digits, &c.) which are not morbid processes, but abnormal facts already accomplished at the birth of the individual. They are presumably due to arrested development or fission of some embryonic part. We may, perhaps, assume some definite anatomical basis for Daltonism or colour-blindness, and range this abnormality in the class we are now dealing with. Daltonism, like the more obvious structural defects I have mentioned, presents both the family and the hereditary tendency, and may, like so many more of the abnormal conditions and tendencies under consideration, illustrate the phenomenon of transmission to the males through the unaffected females.

(4) There are certain diseases in the sense of *abnormalities of function* (*e.g.*, of metabolism and of muscular movement) which may present a family tendency. In this group there are alkaptonuria, cystinuria, hereditary and family tremor, and Thomsen's disease. If gout and diabetes ("the gout of the carbo-hydrate eater") are not allowed to have any anatomical basis, and are therefore excluded from the first and second classes, then they find their place in the fourth class.

Now, while it is impossible to make a perfectly satisfactory classification of all these diseases or abnormalities, the fact forces itself upon us that, in gravity, they are widely different from one another. Take, for instance, diabetes, or pseudo-hypertrophic paralysis, as situated at one end of the series. If a boy suffers from either of these diseases, he is not likely to live to maturity. At the other end of the series we have such abnormalities or freaks as polydactylism, ichthyosis, and alkaptonuria, which involve no danger to life. The hæmorrhagic diathesis involves grave risks to the life of the sufferers, since only 40 per cent. reach their eighth year, and only 11 per cent. reach the age of 22. It makes marriage most undesirable in the case of those who may transmit the tendency. Some of these diseases render life insurance difficult or impossible. In countries where the succession to titles and estates can take place only through the male line, a disease assumes special importance if it threatens to cut off all the males of a family before they reach maturity or become marriageable. Colour-blindness demands careful consideration in its relation to signalling and the safety of travellers by land and sea. Such diseases as severe ichthyosis make men more or less social outcasts, while other flaws amount simply to slight deformities of person, or to inconveniences, or perhaps not even to so much.

It cannot be said that any definite law either explains or sums up the facts we know with regard to these family or hereditary diseases, or abnormalities of structure or function. Nevertheless, certain well-defined tendencies can be recognised, which force themselves on the attention of the student of the subject, though they take him only a little way towards the solution of the question with which he has to deal. Some of these tendencies we may now note.

(1) The abnormality often shows a tendency to keep to one sex in a family, and this may be seen in successive generations of that family. For instance, colour-bindness is far more common in males than in females; the proportion is perhaps 20 to 1. Yet if it happens to begin with a female in a family, it may confine itself to the female sex throughout several generations of that family. Again, a man in whose family there is a tendency to a certain abnormality among the one sex may marry a woman belonging to a family in which there is a tendency to defect among the other sex, the result of the union being that among their descendants both morbid tendencies may be met with, each, however, keeping to the original sex.

(2) Some of these diseases show a strong preference for one sex, commonly the male sex; while others are equally common in both sexes. Among the former are colour-blindness and the pseudo-hypertrophic variety of muscular dystrophy; whilst among the latter are ichthyosis and the two other types of muscular dystrophy.

(3) Some of these diseases which attack chiefly the males are transmitted mainly by the females, and yet these famales do not themselves suffer. This is not accounted for by the fact that the males are cut off before reaching marriageable age, since these diseases do not all shorten life. Hæmophilia furnishes us with one of the best illustrations of this third tendency, and others are supplied by pseudo-hypertrophic paralysis and Leber's atrophy. While colour-blindness may pass directly from father to son, it may also pass from the father through an unaffected daughter to her sons. Obviously, if no males happen to be affected in the second generation (*e.g.*, through there being no males in the family), we may see the disease skipping over a generation, since the females of the second generation act simply as transmittors or conductors.

The tendency so often shown by one or another of these diseases to confine itself to one sex in a given family is an interesting subject for comment. The doctrine of the correlation of parts was one of Cuvier's greatest contributions to the science of morphology. Thus the absence of gills in the vertebrate embryo is associated with the occurrence of the allantois, and the presence of gills with the absence of that fœtal membrane. Animals which ruminate have a cloven hoof. Ungulates which have horns have no upper canine tooth. Darwin called attention to what he called "correlated variation," as observed among varieties belonging to a given species. Breeders, he says, believe that long limbs are usually accompanied by an elongated head. Male cats which are perfectly white and have blue eyes are deaf. White sheep and

pigs are injured by certain plants, whilst dark-coloured individuals escape. Thus Darwin tells how certain farmers in Virginia always selected the black pigs of a litter for raising, because these only had a good chance of living. The pigs ate the paint-root, and this caused the hoofs of all but the black varieties to drop off. Hairless dogs, again, have imperfect teeth. White, yellow, and dun-coloured pigeons are almost naked at birth, whereas those with other colours have a good clothing of down. The tusks and bristles of the boar vary in degree of development along with one another. And other similar instances might be quoted to illustrate the correlation of organs, and the way in which the different parts of the body are intimately connected as members of an organic unity.

This correlation is not constant in the diseases we have been considering, but it is sufficiently striking. Hæmophilia is associated with the organs and attributes of the male sex in 13 cases out of 14, and in colour-blindness the disproportion between the sexes is still greater. It is scarcely credible that nature, so lavish in producing variations, is unable to produce female hæmophilics. Nowhere, I think, does she show her marvellous resource more strikingly than in the power with which she has endowed the living body to produce anti-substances. We introduce a toxin into the organism, and we find molecules of the corresponding anti-toxin already existing in the organism, which, moreover, proceeds to produce more of that same anti-toxin. If we inject a bacterium of any kind into the body, not only does the latter produce an anti-bacterial substance corresponding to that particular species of bacterium, but it seems to have a small quantity of it naturally present in its tissues or fluids, ready in wait, as it were, for a possible attack by the particular species of bacterium. If we introduce blood corpuscles from some other kind of animal, or renal cells, or any other kind of cell, or cell-product, in every case the animal body appears to already possess a certain amount of the specific anti-substance, and this at proceeds forthwith to produce in increased quantity. When we consider the number of the different kinds of microbes, toxins, and foreign cells that may be introduced into the body, the molecular constitution of the latter is seen to be amazingly complex. We can scarcely suppose, then, that nature is unable to produce female hæmophilics if she wishes. Wherein, then, lies the relation between the development of the structures peculiar to the male and the imperfect development of the blood-vascular system in the hæmophilic, or the imperfect development of the colour sense in one who is congenitally colour-blind? This question still awaits its answer.

Some family diseases, among which may be named retinitis pigmentosa and congenital deaf-mutism, have been regarded as a result of blood relationship in the parents of the sufferers. With regard to alkaptonuria, Garrod found that 60 per cent. of the cases were children of parents who were first cousins. Now it is pretty thoroughly established that the closest intermarriage which occurs in mankind is not of itself capable of inducing defects in the offspring. On the other hand, any tendency to defect or disease is naturally much intensified in the offspring of consanguineous marriages. And this defect apparently may be in function as well as in structure. In alkaptonuria, the defect is in the katabolism of proteid matter, whether of the food or of the tissues; in albinism, the defect is in the production of the melanin group of pigments.

Mr. Bateson suggested, some years ago, that the occurrence of alkaptonuria might be explained by Mendel's law of heredity. According to this law, when two germinal cells or gametes unite which have mutually exclusive characters (*e.g.*, black and white), the resulting cell, or zygote, possesses—not a character intermediate between those of its parent cells or gametes, but—both characters. One of these, however, is "dominant" or self-assertive, whilst the other is "recessive," or so inconspicuous as not to be directly recognisable. If, in a future generation, two gametes unite which happen to possess the same recessive character, the latter may reveal itself—the recessive character displacing the dominant. The marriage of cousins is obviously an event which is likely to promote the meeting of such similar gametes. But if a man receives the tendency to a recessive character such as alkaptonuria from his father, his marriage with a maternal cousin is no more likely to produce alkaptonuria in his son than his marriage with any one who is not related to him. In his case, it would be marriage with a paternal cousin which would increase the chance of alkaptonuria in his offspring. In other words, as Garrod puts it, it is not the mating of cousins, but the mating of stocks, that develops alkaptonuria. Whether the Mendelian theory is useful here or not, it is quite in accord with what I have mentioned as the best modern teaching, viz, that the appearance of abnormalities in the children of blood relations is to be attributed, not to consanguinity in itself, but to the heightening of abnormal tendencies which the consanguinity is apt to involve.

The diseases I have touched on in the latter part of this paper are comparable to the variations, or sports, which occur from time to time among animals and plants, either in a state of nature or under domestication. After the observer has become familiar with thousands of normal specimens, he comes across an individual in which a part or organ presents some abnormality of structure, or in which a function is carried out in some abnormal fashion. In such cases, the endurance of the abnormal structure, or the energy of the abnormal function, may be all that could be desired. On the other hand, the diseases dealt with in the earlier part of the paper are characterised by a deficiency in the durability of the tissue or function concerned. Even there, however, it may be supposed that this premature decay or exhaustion has a basis in, and is evidence of the existence of, some natural sport or variation.

As to the original cause of these variations, it may be said that at present we know nothing. It is quite likely that for their elucidation, not simply fresh workers, but fresh methods will be necessary. Modern researches on immunity have sufficed to show how infinitely complicated must be the molecular structure of the living cell; but it is quite conceivable that some instrument of analysis may be invented which will interpret to us the arrangement of molecules in the cell, just as the spectrum has revealed the chemistry of the sun's atmosphere.

Nevertheless, though we think we know a good deal about the physical basis of life, the problem of life itself is still unsolved. Indeed, it is reasonable to suppose that this is about the very last thing that is likely to be worked out on this earth, by all the ingenuity and industry of the finite human intellect. And if this anticipation is correct, then we cannot but be impressed by the distance at which we still stand from the solution of the question, if we accept the dictum of the illustrious philosopher, that the sum of human knowledge is like a sphere, which, as it grows in size, presents an increasing surface of contact with the ignorance around.

References.—W. Sedgwick, "Brit. and For. Med.-Chir. Review," 1861, xxvii., 477-489; xxviii, 198-214; Garrod, "Lancet" 1902, ii., 1616-1620; Darwin, "Origin of Species" (6th edit., 1884), 9, 114-117, 159; W. Bateson, quoted by Garrod (*loc. cit.*), and in "Brit. Med. Jour.," 1906., ii., 67.

The "Bile Beans" Litigation.

THE case of the notorious "Bile Beans" Manufacturing Company has now been taken to the final Court of Appeal, the House of Lords. It will be remembered that both at the first trial in their action against an Edinburgh chemist, and in the subsequent appeal at the Edinburgh Court of Session, the verdict went against the company. They now seek to reverse these judgments, and have engaged the most eminent counsel on their behalf.

THE INTER-RELATIONSHIP OF CANCER, TUBERCLE, AND VENEREAL DISEASES AND OTHER SOCIAL CALAMITIES. (a)

BY C. B. KEETLEY, F.R.C.S.,
Senior Surgeon to the West London Hospital.

GENTLEMEN,—These addresses, and, still more, abstracts of them, are read by the laity. They therefore afford a special opportunity which is often and rightly utilised. Some of you here present are laymen honouring us with your company, and I am certain that no one desires this afternoon to hear anything like a clinical or systematic lecture. I have therefore chosen to deal with questions which ought to interest every intelligent and educated person. It has been said that "every man at 40 is either a fool or a physician." A very small proportion of people at 40, or any other age, are physicians—the author of the saying was not one himself. I hope he was wiser than his aphorism. The less the public fancy themselves to be physicians the better. It is, however, their duty to try to be practical hygienists, and they are deeply concerned with the problems I now propose to touch upon.

The strong general interrelationship of these great questions has, so far as I know, not hitherto been dealt with. Isolated connections are, of course, familiar, such as that of alcoholism with tubercle; but these problems form a series of interlocking chains. To cut one is to help to untie others, and without attacking all it will be scarcely possible to conquer any completely.

West London adults, incapacitated from earning their living by chronic tuberculosis, sometimes sink to reside in such places as Notting Dale. A family driven by ill-health and poverty into this district grows up amid surroundings of crime, idleness, and vice almost unmatched elsewhere in London. The boys are in danger of growing up to drink and loaf, perhaps to steal, the girls to drink and to practice prostitution. Alcohol, poverty, dirt, and the actual presence of the very focus of tuberculous infection which sank the parent into the district, lead to more tubercle, and so the chain winds on.

But things need not be nearly so bad as that, and may yet produce results which differ only in degree. A single tuberculous child, properly treated, is a strain on the resources of either the parents themselves or of the philanthropic. The means even of a hospital like this are weighed down, sometimes almost to breaking, by the strain of such cases, so numerous are they. The funds of all the general hospitals are ground between an upper millstone of tubercle and a lower millstone of the accidents caused by drink. And when a tuberculous child is looked after at home imperfectly it imperils the health even of its parents, and, through that, their monetary and social position. In short, tubercle tends to impoverish and degrade the family, and thus leads to drink, immorality, venereal disease, and physical degeneracy.

Cancer, by destroying the wage-earning capacity of the parent, may result in misfortunes to the children similar to those produced by tubercle; and by killing the mother at an age when her female children particularly need a mother's watchful protection, endangers their character. In these ways cancer tends to the increase of poverty, immorality, alcoholism, and the venereal diseases.

The venereal diseases, by producing chronic ulcerations and old scars, pave the way for cancer. In another curious but well-known manner they interfere with and delay the correct surgical treatment of malignant growths. Owing to the prevalence of syphilis, and the horrible character of operations for cancer of the tongue and neighbouring parts, much valuable time is constantly being lost in giving antisyphilitic treatment to cases which prove to be really malignant.

Through the facial disfigurement and through the defects of the special senses which both acquired and congenital syphilis cause, and through repeated relapses, the choice of occupation and the ability to persevere in it are often greatly diminished; while, if the sufferer be a female, her value in the marriage market is reduced, and she thus tends to sink in society. Chronic gonorrhœa in both the male and the female is a great cause of domestic unhappiness, of quarrels, separations, and consequently more immorality. When contracted before or soon after marriage it is one of the principal factors in lowering the birth-rate; when contracted after the advent of a family, it leads to not a few separations, and the support of two separate establishments impoverishes any family not rich. Of the disease-producing power of poverty it is needless to say more.

By forgetting, or at least ignoring, the reaction of venereal diseases in producing and keeping up immorality, I am afraid the good men and devoted women who attempt rescue work among the fallen waste a great deal of their means.

Roughly speaking, all prostitutes are diseased, and, being physically incurable, are, for that reason, morally only half curable. It is not the old prostitute who is specially likely to be infected. Infection occurs soon after the poor things come on the town, and sometimes before. The men who infect them, though often merely ignorant and thoughtless, are generally, I believe, the hardened sensualists. They naturally seek out the young prostitute. Imperfect morality is very widespread, but I believe that the great majority of public women are infected by a comparatively small number of diseased men.

A rescued woman, after a period of probation and of submission to good moral influence, is often placed out as a domestic servant. Perhaps she marries the baker's boy, and I suppose her rescuers rejoice. But what is she still? Unsound, childless, disappointed, hysterical, and most likely with a taste for intoxicants. What a prospect for both the husband and the wife!

Possibly the so-called "rescue" of fallen women conducted after this fashion does little else than make room for the fall of a hitherto healthy and comparatively virtuous one.

People who busy themselves in rescue work should feel some responsibility for seeing that the poor women are rescuable. They should not be eager to obstruct practical efforts to prevent the spread of venereal disease. I believe I recognise fully the good which religion has done, is doing, and may be expected to do in these matters; but, by itself, its results are very imperfect. Surely, after nearly 2,000 years, the firmest believers might acknowledge this, and be less jealous, less clamant, and less self-opinionated when science trys to assist. But these questions are very delicate. They are ice almost too thin to tread on in the presence of a civilisation which makes itself hideous by the clothes of its males and bankrupt by the dress of its females, and which bows deferentially to any cant masquerading in the name of "Conscience."

On the question of alcoholism, I go as far as Sir Frederick Treves and Sir Victor Horsley. I have done so for many years, and rejoice that they have spoken out. Publicans and their employés suffer out of due proportion from tuberculosis, and from other diseases too, for the matter of that. Perhaps the old student of St. Bartholomew's who is the most famous, is not Harvey, but John Keats, that young poet who in half the domain of poetry stands alone as the equal of Shakespeare. He died at an early age of rapidly progressing tuberculosis. Hear what his friend Hayden said of him:—"Once for six weeks he was hardly ever sober." (Matthew Arnold, "Essays in Criticism," 2nd series, 1891, p. 101).

An old friend of mine used to say that a man might be immoral without being drunken, but not drunken without being immoral. Further, the drunkard is dirty and careless of his person. In this manner the door is opened to other infectious diseases besides tubercle; and the dirty and otherwise neglected home of the drinking woman tends to increased mortality, depreciated health, and the physical degeneracy of her children. Lastly, alcohol, sooner or later, magnifies the weakness of intellect which causes people to resist

(a) An address delivered at the opening of the session of the West London Post-Graduate College, October 10th, 1906.

hygienic reform, and turns it into crass, obstinate, pig-headed stupidity.

And now, what is to be said about physical degeneracy as the first link in an evil chain? It is, of course, often the last. The small, feeble person with flabby muscles, a weak face, open mouth, defective voice, and imperfect special senses, is seriously handicapped in the battle of life. He is ineligible for many positions, he is rejected by the public services, and looked at askance by private employers. He descends in the social scale. He falls in spite of himself into the company of other unfortunates, such as the tuberculous, the alcoholic, and the immoral, and is influenced thereby to his detriment. Mental and physical inferiority tell very hardly on the female sex. The female dwarf on whom Cæsarian section was performed three times for the extraction of illegitimate children would have had probably a respectable history had she not been a degenerate.

There remains another great question of the day, that of the low birth-rate. It is the custom to attribute this wholly to the wilful use of preventives. I think that is too narrow a view to take. Meddlesome and septic midwifery and gynæcology have something to do with it. The great majority of nurses, and not a few medical men, have still no sufficient grasp of aseptic practice either in midwifery or anything else. It is true that years ago things, in the matter of asepticity, were as bad as, or worse than, they are now; but midwifery and gynæcology were much less active and less interfering, especially in country practices. I don't think the country doctor whose pupil I was used the forceps once in three hundred cases. He rarely lost a patient. It is absurd and libelous to suppose that soap and hot water and clean towels were not known and used by decent accoucheurs and even nurses in those days, though it is true they were not used with scientific knowledge and thoroughness. But are they, as a rule, so used now? Is there efficiency in hurried dips in cold antiseptic solutions often of vague strength.

However, I do not wish to make out ourselves and our nurses to be moral degenerates.

The influence of gonorrhœal infection on the birth-rate has already been referred to, and there is also that of syphilis. The former is well known to be the cause of some of the one-child marriages. The only child is, of course, apt to be badly brought up, to be egotistical, and not properly taught the practice of self-control. As it grows up it is fortunate if, for these reasons, it does not set the ball of evil rolling by becoming, if not alcoholic and immoral, at least ill-regulated, undisciplined, and an active cause of disease in itself and others.

In short, all the evils we have dealt with are relations and allies which, in the main, back each other up, and tend to reproduce one another, or at least to help in such reproduction—tubercle, venereal diseases, cancer, alcoholism, poverty, bad housing, physical degeneracy, a low birth-rate, and immorality.

I am well aware that the current of evil is not an absolutely smooth one, always flowing in the same direction. The only child or the small family may be better left or better educated than a child of a large family. But is the final result found to be better? I doubt it. My friend whom I quoted above, and who had no private fortune, has twelve children. All are doing well, and getting from him and their most excellent mother better starts in life than he had himself. Large families do all right when their individual components are willing to go where they are wanted, and to do the kind of work other people want of them; and they are so willing when properly brought up, when healthy, and when free from snobbery.

Even tubercle, which is often a great producer of beauty, has got many a clear-skinned, long-lashed victim a rich and even a good husband.

But such little back washes and returning eddies are not to be seriously set against the main current, whose black course is to perdition.

And now to draw a moral. The first essential is to grasp the idea of the all-pervading influence of the microbe. For rough, practical purposes, and the public cannot be expected to refine, all disease may be regarded as of microbic origin. When we say that a man killed himself by dissipation, or even by drink, or that he died of accidental injury, nine times out of ten the dissipation, the drink, and the trauma would not have been fatal but for the intervention of the microbe. The next thing to remember is that all these microbes have an ancestry—in other words, that we get, practically speaking, all our diseases, either directly or indirectly, from one another. It is time we ceased to blind ourselves and the public by limiting the term "infectious diseases" to narrow classes. A rapid gastric cancer which kills in three months is as much an acute or sub-acute infectious disease as any fever which proves fatal in the same time.

The prophylaxis of all disease lies mainly in sterilisation of food, in limitation of intercourse, in general cleanliness, and in special aseptic and antiseptic precautions, adopted stringently and at the right times, against special risks.

It is now obvious where morality comes into play in the prevention of all kinds of disease, not merely of the venereal affections. Take an extreme case, the ordinary low-class brothel. What a pest-house it must be! Police observation shows that seventy or eighty couples will frequent such a house in one week. Think of its general dirtiness, its closed and curtained windows, its rarely-washed sheets, its alcoholic and unhealthy habitués. And adults are no more proof to infection than children. Perhaps in the frequent references to immorality in this paper, I am thinking more of promiscuity. As a student of science I am certainly not thinking of marriage lines. But, as a man of the world, I recognise that society—at least, in these times—cannot be made sufficiently moral for hygienic purposes without the help of religion, and I frankly say so, hoping that the pious, in return, will help science, or, at least be a little more careful than some of them have been not to hinder her. There is just now so much to be done, that good and sensible men should work together, whether they agree about dogma or not.

I have not referred to fresh air, abundant water, exercise, light, rest, appropriate feeding, and clothing, because their value is now fairly well recognised. In fact, I think the amount and so-called quality of food as factors in the well-being of the individual and of the race are exaggerated. Healthy and vigorous tribes are found living in various parts of the world on many varieties of food, including the almost exclusively vegetable or animal, fresh fish, stale fish, even exclusively shell-fish, getting their meals with the irregularity of the hunter, and yet doing well, so long as the pathogenic microbe holds aloof.

An address like this is no place for detail. Its object will have been served if it has done a little to prove that the great problems on which it has touched require to be considered together as well as separately if they are to be solved, while at the same time every step towards the solution of one should help to make easier that of the others. And I further wish it to contribute, even if very feebly, to persuade the philanthropist, the priest, and the physician to work together as allies.

THE OUT-PATIENTS' ROOM.

ROYAL EAR HOSPITAL.

Affections of the Throat and Nose.

By R. Lake, M.S., F.R.C.S.

Amongst the out-patients was a young married woman, æt. 25, who chiefly complained of a feeling of thickening in her throat, with weakness of the voice, especially when reading aloud to her invalid father. She had been married about five years, but had no children. Two years ago she had attended another institution with this same condition, when she was told she had a relaxed throat, for which, evidently, the galvanic cautery had then been applied. The patient, a nervous, rather foolish young woman,

seemed to have great difficulty in explaining her sensations, and was rather apt to employ pseudo-medical terms, but by leading questions Mr. Lake was able to elicit the following series of symptoms: (1) that the mouth was frequently dry in the morning, with an unpleasant taste; (2) that there was a large amount of discharge (or phlegm) at the back of the throat, giving a feeling as if it came from the back of the nose; (3) that there was a feeling as if there was a foreign body in the throat, this causing a frequent desire to swallow; (4) that the voice was frequently weak, though never entirely lost; and (5) that the patient suffered from attacks of flatulent dyspepsia. On examination the following points were brought to light: In the nose the inferior turbinate bodies showed marked hypertrophic rhinitis; there was a large spur on the left side of the nasal septum running backwards well into the vomer and reaching across to the outer wall of the nasal cavity; the mucous membrane of the vault of the naso-pharynx was red and congested, the uvula somewhat enlarged or thickened, with a moderate amount of granular pharyngitis. The laryngoscope revealed further that the adenoid tissue at the base of the tongue was so hypertrophied as to bring it into constant apposition with the edge of the epiglottis. Mr. Lake pointed out that a series of symptoms which were accounted for by the departures from the normal had been demonstrated as present in this case; thus the dry and rather foul mouth in the morning was accounted for by the nasal obstruction due to the hypertrophic rhinitis and the spur; again, the large amount of phlegm at the back of the throat was due to nasal obstruction, causing hypersecretion in the naso-pharynx, as was evidenced by the hyperæmic state of the pharyngeal vault; the subjective sensation described by the patient as a feeling of a foreign body in the throat was due to the fact that the epiglottis was brought into constant and unnatural contact with the base of the tongue; the swelling of the latter organ was due to its being constantly irritated by mucus passing over it *vid* the uvula, which acted as a gargoyle from the naso-pharynx, the weakness of the voice, again, was a reflex effect due to the unnatural relationship of the epiglottis and the lingual tissues, whilst the dyspepsia was probably originally caused, but certainly aggravated and kept up, by the constant ingestion of mucus. Thus these conditions, Mr. Lake said, really produced a good example of a well-known vicious circle, all the symptoms coming in sequence, the ones behind depending on the ones in front, and all being influenced for worse by the reduction of the vital energies consequent on faulty nutrition. With regard to the treatment, Mr. Lake said that it must be obvious here, as elsewhere in medicine, that certain of the conditions complained of were only symptoms, and whilst efforts directed to their relief might be temporarily successful, no permanent good results could accrue by such methods. There were, therefore, two courses open: the first, more logical and most radical, would be to commence with the earliest source of the trouble—in this instance the nasal passages—remove the spur, reduce the hypertrophic rhinitis to a normal condition; in fact, treat the nose in such a manner that the nasal passages should become equal and sufficient to the needs of the body; from this point the two treatments were the same, and would consist in a frequent painting of the naso-pharynx with Mandl's weaker solution, not omitting the employment of a nasal douche or spray; the use of an astringent gargle to assist in removing the congestion at the base of the tongue, and at the same time the dyspepsia must receive adequate treatment. If these methods were not sufficient to obtain relief from the sensation of a foreign body in the throat and to relieve the weakness of the voice, direct surgical measures would have to be undertaken, consisting in removal of a sufficient amount of the lingual tonsil by means of punch forceps, or by the galvano-cautery and knife.

Influenza has been recently reported on the increase in various parts of the United Kingdom.

OPERATING THEATRES.

CANCER HOSPITAL.

ABDOMINAL HYSTERECTOMY FOR CANCER OF THE UTERUS.—Mr. CHARLES RYALL operated on a woman æt. 45, who had been admitted suffering from hæmorrhage. She stated that she was quite well up to three months ago, the periods being regular. Since then she noticed a considerable loss at the menstrual periods, with intra-menstrual irregular hæmorrhages and some watery discharge of an offensive nature. On examination the uterus was found enlarged, but perfectly movable, the os was patulous, and, on passing the sound bleeding readily occurred, and some small fragments of friable material came away. Carcinoma of the fundus was diagnosed, and as there was no evidence of extension of the disease to other parts, abdominal hysterectomy was recommended. The abdomen was opened in the middle line, the patient being placed in the Trendelenburg position, and a Doyen's abdominal retractor was fixed in the lower angle of the wound. The peritoneum was divided across that portion of the broad ligament external to the ovaries, and the ovarian vessels thus secured; the peritoneal incision was then carried inwards, passing in front above the base of the broad ligament, and crossing the uterus opposite the vesical uterine reflection. An incision was also made through the peritoneum behind both broad ligaments and extending to the cervix. Each broad ligament was thus dissected away from its attachments, care being taken not to wound the ureters, which were carefully dissected out where they ran through the broad ligaments. The uterine arteries were searched for and found and secured where they arose from the external iliacs. The bladder was then dissected off the anterior surface of the uterus and the upper portion of the vagina. The latter was then incised in front and the incision carried round the vagina, thus liberating the uterus. There was no bleeding, but some slight oozing occurred from the vaginal walls, which was checked by bringing the latter together by sutures, thus shutting off the vagina. There were no enlarged glands to be found anywhere in the pelvis, so the pelvic floor was completed by carefully suturing the divided peritoneum from one side of the pelvis to the other. The abdominal wound was closed in three layers. Mr. Ryall said he did not think that vaginal hysterectomy was ever performed nowadays by those who were accustomed to deal with cancer, though it had been a useful operation before the technique of abdominal hysterectomy had been perfected. The abdominal route, he thought, was undoubtedly the proper way to grapple with such a disease. The vessels were more easily tied, and wider excision could be carried out, including that of the surrounding cellular tissue, the glands, and the upper part of the vagina; besides, it was more satisfactory to the surgeon to feel he had done everything possible for his patient. In an extensive case, it was quite impossible, he considered, to operate by the vagina owing to the necessity of dissecting out and protecting the ureter. The latter was very easily found attached to the reflected peritoneum, and could be followed where it entered the base of the broad ligament, crossed the uterine artery, and entered the bladder; in all operations it was important, he remarked, to dissect it clear of the surrounding tissue as little as possible owing to the danger of cutting off its blood supply, and so causing consequent necrosis, but, ortunately, it was only that portion in the base of the. broad ligament that need be interfered with. Mr

Ryall said he believed in operating on even extensive cases if there was the least chance of getting the disease away, as operating for malignant disease often gave surprising results. There were many cases, he pointed out, in which it was impossible to settle the possibility of operation without abdominal exploration. With regard to Doyen's retractor, he found it of great service in all pelvic operations, as it kept open the abdominal wound and thus facilitated any suturing in the pelvis.

The patient made un uninterrupted recovery.

TRANSACTIONS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON.

MEETING HELD FRIDAY, NOVEMBER 9TH, 1906.

The President, Mr. CLUTTON, in the Chair.

Dr. E. DIVER read a paper entitled

A PRINCIPLE OF TREATMENT SUGGESTED FOR SOME UNTOWARD FRACTURES, ESPECIALLY OF THE FEMUR.

The treatment suggested varied from that generally in vogue, in that where good apposition is not attainable effort is directed to gaining *contact* merely of some portion of the broken ends of the bone, regardless of the contour of the limb, until callus is beginning to fix the fracture, and then to seeking restoration of the normal outline by movements alternating with periods of rest, much as in a case of tenotomy. So that callus as it is hardening shall yield as the surgeon's manipulations change the relative position of the fragments, until the limb is as far as possible in symmetry with the other. In some cases the effect of muscular action would be to aid in maintaining the fragments in the position the surgeon might place them in. The principle of treatment was similar to that governing the treatment of club foot.

Mr. CHARTERS SYMONDS read notes of a case of

MULTIPLE STRICTURE OF SMALL INTESTINE, PROBABLY OF TUBERCULAR ORIGIN.

G. W., æt. 43, was admitted into Guy's Hospital September, 1893. Since a boy subject to abdominal pain. Married at 20, and his wife said he had one or two attacks of pain a year. They occurred at night, and disappeared by the next day. He was first seen on August 30th, 1899, and said that the attacks had been more frequent the last three years. There had been almost constant pain for the last three months. The abdomen was big, coils of small gut could be seen, there was loud gurgling, and a marked sound as of fluid passing a narrow orifice. He was very thin indeed, but no signs of tuberculosis were ever found. On September 5, 1899, the abdomen was opened, and resection with end-to-end anastomosis was carried out. The portion removed was 15 inches long, and showed a thickened and dilated length of bowel, with a stricture at either end. The dilated portion was the size and shape of a small stomach, and about 12 inches in length. The strictures were 1½ inches long. The man has had no return of symptoms, and is at present in perfect health. Reference was also made to a similar case that occurred in a child.

Mr. F. J. STEWARD narrated a similar case in a man of 37, who was admitted into Guy's Hospital with symptoms as of duodenal ulcer. There was bad pain behind the upper part of the right rectus. At the operation two strictures were found, with no evidence of tuberculosis. Resection was performed successfully.

Mr. A. E. J. BARKER suggested typhoid as a possible cause of the strictures. He had seen similar cases occurring after strangulated hernia. He laid stress on the accumulating evidence that shows the importance of excising larger sections of intestine than we were wont to; there was little or no increase in shock with the more extensive operations. He dealt fully with the problems of technique, and suggested that lateral anastomosis was preferable to end-to-end joining when the lumen of one gut was so much smaller than that of the other as to necessitate a tuck.

Mr. CHARTER SYMONDS replied.

Mr. EDRED M. CORNER, in a paper upon

ROTATORY SUBLUXATION OF THE ATLAS,

drew attention to those cases in which, as the result of violence such as a sudden twist, the head becomes fixed in a rotated position. This, he concluded, was the result of the locking together of the forwardly displaced side of the atlas on the axis by muscular action. The position and fixation of the atlas can be demonstrated clinically by the position of its transverse processes, and by the movements which the head can perform. The latter are somewhat difficult to understand, and were demonstrated by means of diagrams. Cases were quoted in support of these statements. A skiagraph was mainly of use to demonstrate the absence of complicating injuries, such as a fracture of the odontoid process or of the anterior arch of the atlas. If such additional fractures are excluded, an anæsthetic should be administered slowly. If muscular relaxation is induced, the head would probably roll back into its proper position, so that when the patient comes round, full movements of the head are restored. These accidents have usually been attributed to the displacement of the part of the splenius muscle or to the slipping of one of the deep tendons over the transverse process of a vertebra.

Mr. STEWARD asked whether subluxation might occur with intact ligaments.

Mr. CORNER said they were so loose that the occurrence was certainly possible, as he had often demonstrated on the cadaver.

Mr. JACKSON CLARKE read a paper on

CONGENITAL DEFORMITY OF THE SPINE.

The patient, a boy, æt. 4, had the head fixed from birth so that the chin was close to the sternum, and there was no movement in the cervical spine, either of flexion and extension or rotation. The general appearance recalled cases of anencephaly. The boy's mind appeared to be normal. Operative treatment, followed by massage, gave the boy a short neck with all the natural movements. Skiagraphs showed extensive abnormalities in the form of the bones in the upper dorsal and cervical regions, and a cervical rib was present on each side.

The PRESIDENT agreed with Mr. Clarke that the origin of the deformity might have been an anterior spina bifida in the cervical region.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF PATHOLOGY.

President: J. F. O'CARROLL, F.R.C.P.I. Sectional Secretary: Professor WHITE, R.C.S.

MEETING HELD FRIDAY, OCTOBER 26TH, 1906.

Dr. ARTHUR H. BENSON in the Chair.

PANCREATITIS.

Dr. EARL exhibited a pancreas, omentum, and portion of mesentery from a case of pancreatitis. The two latter showed well marked and extensive fat necrosis.

Dr. W. G. HARVEY exhibited specimens, and stated that in his case the patient, aged about sixty, and a fairly stout man, had been complaining of vague pains in the abdomen for four or five days before coming into hospital. He had been drinking heavily, and one morning on going into a public-house fell unconscious, and was brought to the Adelaide Hospital. On admission he was quite unconscious and breathing heavily. He died in a few minutes. Post-mortem showed (1) fat necrosis over the abdominal and mesenteric fat; (2) pancreas enlarged, swollen, dark, friable, and on section showed several large hæmorrhages; (3) gall bladder somewhat distended, but no gallstones. Microscopically the pancreas showed necrotic and hæmorrhagic areas.

Dr. MCWEENEY said it would have been interesting

to learn exactly how it was that, in the specimen shown by Dr. Earl, such a relatively small amount of pancreatic destruction could have resulted in such very extensive fat necrosis. He would also have been glad to know why the fat-splitting ferment exercised its effects upon certain small and isolated areas somewhat removed from the pancreas, while it appeared to spare areas in immediate contact with the pancreas. In regard to Dr. Harvey's specimen, he (Dr. McWeeney) was under the impression that the hæmorrhagic pancreatitis was a microbic affection; but the surgeons present would be able to say whether such hæmorrhagic cases ever went on to genuine suppuration.

Dr. PARSONS expressed regret that, owing to the brief time during which the two cases were under clinical observation, it would hardly be possible to obtain answers to all the questions to which they gave rise. He would have liked to know when the cases had been first recognised as pancreatitis, and whether any sugar or Cammidge's crystals were found in the urine. Such crystals might have considerable importance in the diagnosis of pancreatitis—a matter always of great difficulty.

Dr. EARL, in reply, said he had little to add to what he had already stated. They had still to find out a good deal more about the subject than they already knew. He had not had an opportunity of examining the patient's urine, as he was operated upon immediately he was admitted to hospital. He would only add, in conclusion, that the ducts were not affected in any way, and there were no gallstones.

Dr. HARVEY, in reply, regretted that, owing to a hurried post-mortem for the Coroner, he had not been able to make a complete bacteriological examination. He had stained a section by Gram's method, but found no organisms.

CARCINOMA OF BREAST, WITH SECONDARY GROWTH IN HUMERUS.

Mr. JAMESON JOHNSTON detailed the history of a carcinoma of breast, with secondary growth in humerus, and showed microscopic slides.

Dr. MCWEENEY said that, while, as a rule, he was able to say right off whether or not a breast tumour, sent for examination, was a cancer, occasionally a difficult case would crop up like the one described by Mr. Johnston. He recounted, in detail, a case exhibiting characteristics which at first sight appeared to be cancer, but which turned out to be a case of interstitial mastitis. He mentioned the case as an example of the difficulty sometimes met with in cases of breast tumours. It had always occurred to him as peculiar that, although breast cancers are so common, he had never seen a case of secondary cancer of the bone diagnosed in hospital or found in the post-mortem room. This was probably because such cases seldom remained in the hospital to the end.

TRICUSPID STENOSIS.

Dr. BOXWELL exhibited a heart showing well-marked tricuspid stenosis, together with lesions of the mitral and aortic valves.

CRYOSCOPIC WORK.

Mr. L. G. GUNN read a short note on cryoscopic work done during the past two years, showing that the information obtained from this method was similar to that obtained by a quantitative analysis of the urine, or the blood, or the accurate reading of the specific gravity, provided the fluid had been deprived of proteids. The method of finding the freezing point was demonstrated by means of Beckmann's apparatus. Mr. Gunn believed that slight alterations in the freezing point of the blood were of far greater importance than considerable alterations in the molecular concentration of the urine. In no case in which normal urine readings were obtained did the kidneys show any functional deficiency after the removal of the other kidney. On the other hand, in two or three cases, patients with only one kidney remained healthy, although the urine showed a molecular concentration considerably below normal.

Dr. MCWEENEY said that he had not been convinced, either by his reading on the subject, or by the communication just made, that the diagnostic advantages to be derived from cryoscopy of the urine would compensate a hard-worked pathologist for the labour involved in working the apparatus which had been exhibited. It was acknowledged that the lowering of the freezing-point was a valuable indication of molecular concentration; but he failed to see the necessity for the method of cryoscopy, when it was always possible for a man—who was clever and patient enough to carry out cryoscopy—to determine accurately the total solids after removal of the colloid constituents, or to take the specific gravity accurately. What applied to urine applied also to the blood; and, as the latter coagulated with considerable activity, he thought it was a difficult matter to saturate a sample with oxygen, as mentioned by the communicator. In his opinion one would have to be pretty sure of his technique in order to draw wide inferences from the delicate data and slight divergences from the normal which were obtained by cryoscopy. He considered that simple methods, such as the taking of the specific gravity, gave just as useful results; and he was glad that the knowledge which he had gained from Dr. Gunn's authoritative statement had not imposed on him any change in his personal practice.

Dr. GUNN, in reply, said he had taken up the subject of cryoscopy, because he believed that by it much might be found out about the condition of the kidneys. The time and labour involved were not very great; two or three readings of half a dozen samples could be taken in an hour; and it was, of course, necessary that the *mean* of two or three should be taken. He did not deny that the specific gravity gave an equally good demonstration of the molecular concentration, but in that method all the albumen in the urine had to be got rid of. He thought the only way to advance knowledge was by trying every method, and the only way to ascertain the value of cryoscopy was by using it.

ULSTER MEDICAL SOCIETY.

THE Opening Meeting of the Session was held in the Medical Institute, Belfast, on Thursday evening, November 1st.

Dr. CALWELL, President, took the chair, and, in a few words, thanked the members for their kindness to him during the past two years, and expressed the pleasure he felt in introducing to them as his successor his old college friend, Dr. David Gaussen.

On Dr. GAUSSEN taking the chair, Mr. ROBERT CAMPBELL moved, and Dr. O'MALLEY seconded, a vote of thanks to Dr. Calwell for his services to the Society as its President during the past two years.

Dr. GAUSSEN then proceeded to deliver his inaugural address. He began by referring to the chief events of medical interest to the members of the Society during the past year—the successful issue of the movement for the better equipment of Queen's College, and its bearing on medical research work, the portrait of Edward Jenner presented to the Society by Sir Otto Jaffe, the honour bestowed on our old fellow-townsman, Sir A. E. Wright, the result of the Darnell case, and, lastly the death of one of our Fellows, Dr. James Lynass. As the subject on which to address the Society, Dr. Gaussen chose "Some Recent Advances in Scientific Medicine, and our Duty Regarding them." These advances were so great that it might seem as if it would soon be impossible to follow all, and that the great class of general practitioners, to which he himself belonged, would cease to exist, and only specialists would survive. But the human body was not a mere collection of machinery, and there was something in man, and might he say more particularly in woman, which was a law unto itself, and with which as medical men we could never deal successfully till we recognised the influence of mind over body. He believed that this complex question of the extent to which the brain

influenced the body, and *vice versa*, was not enough studied, and he looked forward to the future when this influence would be recognised as one of our most valuable therapeutic agents. We have left such things too much to the quack and the charlatan, but we are morally bound to study scientifically all means whereby our patients may be benefited, and medical psychology must not be limited to the study of mental disorders, but extended to the influence of the mind on the body, both the particular body governed by that mind, and other bodies as well. The healing powers of nature must be directed to some extent by the psychic centres, and since we recognise nature as the best physician, and we her humble assistants, should we not consider the possibility of control? In the course of five years study the medical student has not one minute for such subjects; he hoped the day would come when medical psychology would be a compulsory subject for the student. Dr. Gaussen then dealt with the subject of recent introductions of new drugs, our knowledge of them, and the art of prescribing them. The busy practitioner was bewildered by their number, and while many were useless no doubt some were really valuable, but he obtained little help in selecting from them, except the recommendations of financially interested manufacturers. Regarding secret or proprietary remedies, again, the orthodox position was absurdly weak. Some such remedies were undoubtedly valuable, and our patients' welfare should be our first consideration. On preventive medicine, Dr. Gaussen expressed very pronounced opinions, believing that treatment on the lines followed by Wright would be the treatment of the future in many diseases. In spite of the vast possibilities ahead, however, he did not think we need expect to get rid entirely of diseases such as tubercle. For their better prevention nothing would avail so much as the scientific education of the general public, carried out by medical men. He advocated also the instruction of school children in hygiene and the elements of sanitary science, and specially in the means to be taken for the prevention of consumption and infectious diseases.

At the close of his address a cordial vote of thanks was accorded to the new President on the motion of Dr. John Campbell, seconded by Mr. A. B. Mitchell.

It was announced that the annual dinner of the Society would be held in the Institute on Thursday, November 15th. At the close of the meeting tea and coffee were provided by the President.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

Clinical Meeting held November 2nd, 1906.

The President, Dr. Leonard Mark, in the Chair.

The following cases were shown:—

Dr. Saunders: Two Cases of Congenital Œdema of the Legs.

Mr. Baldwin: (1) Case of Dislocation of the Hip reduced by open operation. (2) A man, æt. 31, on whom he had performed Excision of the Knee for Tuberculous Disease of long standing.

Mr. Keetley: Two women on whom he had performed the operation of Appendicostomy with satisfactory results.

Mr. Pardoe: (1) Malignant Tumour of the Neck. (2) Abdominal Tumour.

Mr. Cecil Leaf: Cases of Tumour of the Breast.

Dr. Seymour Taylor: Case of Locomotor Ataxia in a woman.

Dr. J. Wallace: A boy, æt. 7, suffering from Lymphadenoma of Glands of Neck.

Mr. Donald Armour: A Case of Tumour of the Scalp.

Dr. Phineas Abraham: Case of Pityriasis Rubra.

THERAPEUTICAL SOCIETY.

A report of proceedings at the last meeting of this Society (sent in officially) having appeared in our columns on November 7th, we are asked to publish the following note in our present issue:—"The Secretary regrets that the reporter of the discussion at the last meeting of this Society was under a misapprehension as to what Sir Lauder Brunton said. Sir Lauder Brunton has had *no* personal experience of the therapeutic uses of preparations of violet leaves."

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Nov. 11th, 1906

Treatment of Varicose Veins.

The medical treatment of varicose veins should have a triple aim: Attenuate the existing symptoms, diminish the venous dilatation, prevent grave complications, of which rupture of the vein and elephantiasis (induration) of the skin are the forerunners.

The treatment, says Prof. Robin, should be at first hygienic, comprising hygiene in standing and hygiene in walking.

Patients should avoid as far as possible standing for any length of time; they should either be lying down or walking. As the blood only flows in the veins by muscular contraction, it is better to advise walking, on the condition that it does not cause pain or inconvenience in the legs. All constriction of the veins by garters should be suppressed.

The teguments should be maintained absolutely clear, and the function of the intestine carefully attended to, especially in women, in whom constipation is so frequent. No alcohol nor spiced food should be allowed, and the patients will be enjoined to observe as much as possible a vegetable diet.

The medical treatment will give good results, provided it is persevered in. To stimulate the muscular coats of the veins, the following drops should be ordered, and continued for a long period:—

Tincture of Hamamelis virginica
Tincture of Viburnum prunifolium aa 6 drachms
Six drops in a little water every morning.

To diminish the process of sclerosis, iodide of potassium is a good agent, prescribed in small doses (2 grains) and continued for months.

The local treatment is very important, but rather difficult to get the patients to accept. The limb should be enveloped every night in compresses of lead lotion covered with cotton wadding, oil silk and a flannel bandage.

If this treatment be not accepted, the parts should be coated very lightly each evening with:—

Iodide of potassium	1 dr.
Ergotine	1 dr.
Extract of Nux Vomica	xv. grs.
Benzoate lard	1 oz.

As local mechanical treatment, the use of the elastic stocking would be necessary, but it costs dear, wears out quickly, and is suitable only for persons who are aware of the necessity of keeping it absolutely clean.

For the working classes, Velpeau's elastic band is the ideal; it should be long enough to go from the foot to the inguinal region. Put on in the morning, it is taken off at night. In any case, the elastic stocking is more harmful than beneficial, unless it reaches above the knee.

Besides this passive mechanical treatment, massage should be advised. The hands, coated with vaseline, should be passed lightly over the limb from below upwards for a quarter of an hour, morning and evening. The massage is more efficacious after a bath, however. A bath might be prescribed three times a week; the patient remains half an hour in the bath and then goes to bed. It is at that moment that the massage should be done, and, where possible, by the medical attendant himself.

HÆMATEMESIS.

Frequently gastric hæmorrhage is so abundant that the classic absolute diet is insufficient. Injections of ergotine produce but temporary relief; it is evident that gastric mucuous membrane itself must be treated. Absorbing powders seems to have only a neutralising effect, and without any effect on the hæmorrhage. Small pieces of ice given by the mouth, and the ice bag to the stomach, is good treatment. In case of abundant blood vomiting, Boas tells of having employed with success washing of the stomach with iced water, but that treatment is difficult, if not impossible, in private practice.

The following jelly given by teaspoonfuls has proved very successful in the hands of Prof. Œttinger, of Paris.

Gelatine	1 oz.
Sugar	1 oz.
Syrup of lemon	1 oz.
Water	vj oz.

This jelly is agreeable to take, and does not increase the pain nor the gastric acidity. While the hæmorrhage lasts, two or three injections of serum of six ounces each should be administered, and the treatment will be completed by two enemas of water of the same quantity, to which a few drops of laudanum should be added.

GERMANY.

Berlin, Nov. 11th, 1906.

QUACKERY IN GERMANY.

QUACKERY flourishes here in spite of all efforts to repress it, although these efforts are not few; neither, however, are they without some result. There is a society for the *Bekämpfung* of quackery, or *Kurpfuscherei*, as it is harmoniously called, just as there are societies for the *Bekämpfung* of tuberculosis and cancer. What its numbers are I do not know, but it is known that it is actively engaged in fighting quacks and quackery wherever there is a chance of obtaining a conviction, and in throwing a healthful light over the dark doings of quacks. The official organ of the society is the *Hygienische Blätter*, published by Dr. Carl Reissig, of Hamburg. From the October number of the *Blätter*, we learn that during the past year forty-eight quacks have been prosecuted with success. In a supplement accompanying the monthly report is a tabulated record of the cases that furnishes interesting reading, as it gives along with the name of the offender his (or her) specialty, former occupation, previous punishments (as in the case of No. 1, who had already served a term of seven years in gaol), method of treatment adopted, sentence, and date of time and place. No. 1 was convicted of an offence against decency and sentenced to three years' imprisonment with hard labour; No. 2 to five months' imprisonment for causing bodily injury through culpable negligence; No. 3, for obtaining money under false pretences, one month's imprisonment. A maker of "Kraftpulvern" a director of a theatre, was fined 100 marks for deception. A man named Fauser, styled a "homœopath," who had been frequently punished before, was sentenced in April last at Cologne to nine months' imprisonment for "causing bodily injury through negligence." Friedrich von der Filten, a bone doctor, formerly a non-professional attendant, was fined 500 marks at Cologne for the same cause as the last. The next case is of special interest in view of the notorious Mrs. Eddy's approaching end. The culprit was a lady who was a professional health-prayer (*Gesundbeterin*). She treated cancer of the breast by means of medicaments and prayers, and was sentenced to one month's imprisonment for cheating at Munich in March last. This lady exacted an honorarium of 145 marks. The next was a bad case, and is that of "nature artist." He also had been many times in the house of correction. He treated ulcers of the cornea with inunctions of almond oil, and in the case or which he was convicted the eye of the patient (a boy) burst through the ulcer and the sight was irretrievably lost. He was sentenced to one year's "imprisonment" for causing bodily injury through negligence. The next was a man named Harromer, but who called himself Graf Clairveux, and whose clients were mostly females. His cases were treated with worthless drugs and in so far did no bodily harm. He was convicted as a cheat, however, was fined 1,000 marks, sentenced to three and a half years in the Zuchthaus (House of Correction), eighteen months' "imprisonment," and five years' "deprivation of honour" (*Ehrverlust*). This man had been repeatedly punished for previous offences, so that he was an old offender. Auguste Knopp, the wife of a blacksmith, treated all sorts of diseases. She was sentenced to fourteen days' imprisonment and a fine of 500 marks for cheating. Her mode of procedure was eminently artless, and the very essence of simplicity. She burned broom twigs and, after putting them in water, sprinkled her human and bovine patients with the water. And a brutal magistrate sent her to gaol for this! A gentleman, an expert in teeth, or *Zahnkünstler*, was sentenced to four months' imprisonment for false pretences. His offence was that he extracted sound teeth in order to replace them by his own artificial ones, which, however, were not even of good quality. The next on the list was a swindler of a philosophical turn of mind, and who, evidently as the result of long contemplation and study, articulated his thoughts into words and wrote them down in his diary. As they contain a great deal of wisdom they are worth reproducing. The bright jewel of wisdom is as follows:—"So lange die Toren nicht aus der Welt verschwinden wird unter ihnen stets ein Kluger sein Brot noch finden," which may be freely rendered: "So long as there are fools in the world a clever chap will get his living out of them." He posed as a magnetopath, whatever that may be. He had been many times in gaol. His stock in trade with which his patients were treated was wadding shirts and "magnet water." The offence for which he was sentenced to six months' imprisonment was homicide through criminal negligence.

It may be here mentioned that in Germany there are three grades of punishment by imprisonment. The third or highest grade is that of the "Zuchthaus," which is equivalent to imprisonment with forced or hard labour. The second is simple imprisonment ("Gefängniss"), without the exaction of forced labour, but the prisoner may work if he expresses a desire to do so. The first, or lowest, is not called "imprisonment" at all, but simply "custody," or "detention" (Haft). The shortest term of detention of "Haft" is twenty-four hours, and the longest six weeks. The last offender was sentenced to "Gefängniss." It will be observed that in some sentences the same offender undergoes imprisonment in more than one grade, as, for instance, the man who is sentenced to three and a half years' "Zuchthaus," eighteen months' "Gefängniss," besides a fine, or "Geldstrafe," of 1,000 marks.

The offences for which others were punished were: Frequently the criminal infliction of bodily injury, obtaining money under false pretences (by pretending to treat cases, &c.), the unlicenced sale of drugs, as when a man was fined for selling chloroform and extract of filix mas for tapeworm; indecency under pretence of massage, dishonest mode of life, pretending to set dislocated limbs but failing to do so to the injury of the patient, procuring abortion (one and a half years' "Gefängniss"), falsely assuming a professional title (200 marks and 10 marks); deceiving the public by pretending to cure baldness and using sharp remedies for the purpose. This case is interesting as the offender represented himself to be only a representative or agent of a certain John Craven Burleigh. One city quack professed to cure by "personal magnetism," another by "sympathy" remedies, another by packings and gargling, another treated cancer of the uterus by magnetism, massage, and baths. This offender was let off very easily, only getting one

year's "Gefängniss" for homicide by culpable negligence. Still another, a shoeing smith, treats diseases by "drops and rubbing," and another treats ruptures "homœopathically," but how this is done is not explained. It certainly requires a considerable amount of dexterity to accomplish such a feat. One lady practises by magnetism *and* telepathy. Her current of telepathy she claims reaches 125 German miles. She adds to these wonders the pretensions of a teacher of singing, piano-playing, and dancing. One had discovered the "Fountain of Perpetual Youth," and proceeded at once to exploit it.

The love of the marvellous and the belief in it are, however, ingrained in human nature, and will remain in spite of schools and science. It is very meritorious and laudable, however, to endeavour to light up what is mysterious and dark and to frustrate as much as possible the sinister design of those who would prey on human weaknesses.

AUSTRIA.

Vienna, Nov. 11th, 1906.

GANGRENA PEDIS.

AT the "Geseilschaft," Mcszkowicz showed two cases of Raynaud's disease, and endeavoured to prove that it was possible to locate the site of the morbid changes and thus define exactly the extent of the operation necessary in the event of amputating. The first patient he had experimented on was a waiter, æt. 57, who complained of pain in one of his legs, which caused him to walk with a halt. This soon became intermittent in character, and, as subsequent evidence proved, was due to the narrowing of the lumen of the arteries of the lower extremity, following endarteritis obliterans, or possibly an organised thrombus, either of which would lead to a thickening of the fibrous tissue and intima of the vessel.

The second case was a shoemaker, æt. 37, who had lost the fourth and fifth toes of the left foot five years ago through gangrene. He still complains of pain in the lower extremities.

Moszkowicz here related his experiment of placing an indiarubber band on the upper part of the leg as a tourniquet, and relieving it after five minutes' application. In a normal leg where the circulation is healthy, the flow of blood will commence in the tourniqueted limb immediately the indiarubber band is relieved, but this is quite different where the circulation is interfered with through morbid changes. In Raynaud's disease, the hyperæmia in the thigh is rapid and extends to the patella, but stops suddenly at that point, which stands out in bold relief when compared with the lower part of the leg. In the course of two or three minutes, the hyperæmia slowly invades the toes, passing sluggishly from one toe to the other, till finally it is observed to pass over the points. In the second case of Claudication intermittente, the progression of the hyperæmia was still more sluggish and the demarcation more marked. This symptom, he thought, was an excellent guide for determining the height that the gangrene might rise to, although an error might arise in observing the hyperæmia in the cutaneous surface, as it is doubtful whether this relationship in the circulation exists in the lower tissues corresponding to the superficial.

Fuchs remarked that this point in the diagnosis was of immense value to the surgeon. He had practised it on a small scale and found the relative closing of the vessels prominently marked, and is of opinion that where there is an intermitting lameness this method will be of great service in the diagnosis.

Iselsberg related the history of a case with gangrena pedis rising from arterio-sclerosis, where he had to perform a small amputation of the toes, and after relieving the Esmarch tourniquet, hyperæmia extended down to the knee, but the lower part of the leg remained perfectly white. Later the gangrene speedily increased upwards, necessitating amputation at the knee-joint. A microscopical examination of the amputated portion showed that the cutaneous vessels were almost closed.

Schnitzler thought that all were agreed on the importance of the diagnostic symptom, but the doubt still existed whether the cutaneous surface or the deeper circulation represented the morbid changes. Another point he would like to be clear about was the central extension of the hyperæmia not then invaded by the gangrene, or was it certain to stop at the margin of the hyperæmia? It often happens that in senile gangrene where lymphangitis is present the hyperæmia is the herald for a speedy destruction by gangrene with a resulting amputation.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

PUBLIC HEALTH ASPECTS OF CONSUMPTION.—The session of the Edinburgh Sanitary Society was opened on November 3rd by an address by Dr. R. W. Philip on "The Public Health Aspects of the Prevention of Consumption." He pointed out that although twenty-five years had elapsed since Koch's great discovery, the community at large had not yet derived the practical benefit from it which might have been anticipated. To this result certain natural causes had contributed. In 1881 the world was not prepared for the swift intimation that consumption, whose nature then was regarded as ascertained, had been thoroughly misunderstood, and that in place of depending on a variety of ill-defined causes, it was due to a specific micro-organism. Although the change which had come over the pathological conception of the disease during the last quarter of a century was immense, and had led to great strides on the therapeutic side, much still was called for in regard to the more public aspect of the question, and there was clamant need for a vastly wider organisation and co-ordination of measures than had yet been recognised. The solution of so far-reaching a social problem could only be attained by concerted action throughout the country. Any scheme should include the following factors:—(1) Notification of the disease; (2) a tuberculosis dispensary; (3) a hospital for dying patients; (4) sanatoria for selected cases; and (5) colonies for residence of latent or arrested cases. Compulsory notification afforded the only sound solution of the consumption problem. It was often asked, After notification—what? Notification did not imply that all affected persons were to be removed to a hospital. In some cases, however, it would lead to the discovery of a whole nest of the disease, and then compulsory notification would lead to a vast number of questions as to how the focus of infection should be dealt with.

COMPLIMENTARY DINNER AND PRESENTATION TO DR. T. M. BURN MURDOCH.—Dr. Burn Murdoch, who has lately resigned his position as Senior Physician to the Royal Hospital for Sick Children, after a period of service extending to nearly a quarter of a century, was entertained to dinner on November 10th by his colleagues on the hospital staff, his former residents, and his old assistants. Dr. Melville Dunlop occupied the chair, and in a felicitous speech proposed the guest's health, at the same time asking his acceptance of a piece of plate in token of the feeling of affection and esteem which all those who had been associated with Dr. Burn Murdoch felt towards him.

EDINBURGH ROYAL INFIRMARY.—At last week's meeting of the managers, it was reported that Dr. J. Malcolm Farquharson had been promoted from the post of Assistant Surgeon to that of Junior Full Surgeon to the Ear and Throat Department, with a share of the beds. The following gentlemen were appointed Clinical Tutors for the current winter and ensuing summer sessions, viz.:—Alexander Goodall, M.D., F.R.C.P.Ed., to Dr. Alexander James; W. G. Porter, M.B., B.Sc., F.R.C.S.Ed., to Dr. Logan Turner. Re-

cognition was taken of the retirement of Dr. Allan Jamieson from the post of Physician to the Skin Department of the Infirmary, to express to him their grateful thanks and in token of their esteem and in acknowledgement of his services, they appointed him Consulting Physician.

LETTERS TO THE EDITOR.

THE GENERAL COUNCIL—THE ELECTION.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—The approaching election of direct representatives invites contemplation. Our discussion shall be calm and philosophical. And on first glancing through the various addresses, no definite issue nor distinct principle appears. Each candidate seems in breathless haste to tell us what he has done, what offices he has held in the various professional societies and associations. Yet we see from this that the decision must turn on the personal qualities of the candidates—not only their beliefs, but their power of expression and their power to persuade indifferent or opposing members of the Council. Herein is an argument for the division of England into electoral provinces, for few men can be very widely known for their administrative qualities.

The next feature is the absence of enthusiasm for reform. Of course, they all say that their number should be increased. That is the proper thing to say. One candidate advocates reform *on the lines* of the Bill proposed by the Association. Only one, I think, goes in for the whole Bill.

The demand for increase in the number of direct representatives, *i.e.*, for increased influence on the Council, goes to the heart of things. It means there is much to be done and none but those who form the great bulk of the profession—the practitioners—can understand either what to do or how to get it done. Consider these cases.

An old man who has toiled all his life as an Irish dispensary doctor receives, at 70, no pension, and is sent into the workhouse. Would this be possible if the Council represented and had truly looked after the interests of the profession?

It is an old story, that of the unqualified assistant. Many were fairly skilful in many ways, steady and hard-working. They were turned off without fault of theirs, without compensation, and so far as the Council cared, left to starve. Let us not forget that, although less competent, they filled in some ways a useful transitional stage, and in a sense were members with us of one calling. Good and bad were treated alike.

What has been the answer of the Legislature? By the Midwives Bill, a class of subordinate practitioners has been again created: women, with no general education, far less qualified than many of the late unqualified assistants. When this Act was passing, the Council were asleep. Their voice was feeble *because* they do not in truth represent the profession. These consultants and lecturers are in us, but not of us.

A man in Aberdeen got drunk. He was struck off the *Register*, and I do not read that any hand was lifted up against it, or that anyone asked that he should have another chance. I know nothing of the fellow: what trials, what disappointments brought him to take an overdose of the anæsthetic. I would like to know though, if the secretary of a Division, or a member of a Branch Council, attended at the police-court to take the man by the hand and attempt his reformation. I wonder, also, when those well-to-do members of the General Medical Council had gone home and were sitting in their warm dining-room over the walnuts and the wine, if they had any thought of their Brother outside in the dark, whom their action had thrust a little deeper into hell. For the man from Aberdeen is not one man. He is a hundred men. We cannot tell how many. One by one they sink beneath the surface and are forgotten. Is it not for those who represent a humane profession to look after the weakly ones? But have I said "wine"? I made a mistake. If it be infamous to get drunk, it is surely infamous to drink. Possibly there are degrees in infamy.

Yet another case. This, a rich man, or at least well-to-do, living in his own house. He was trustee, and mismanaged the trust; he spent the income on his own pleasures. This is nothing to the General Council—not meriting even an inquiry. This man is not as that poor drunkard, who had no friend in the world. This one is well off. So that to rob the orphan is no offence—at least, if you are affluent.

Have I been able to make my meaning clear? It is: that excellent as are strictness in examinations, and a reasonable standard of honourable conduct, *i.e.*, professional etiquette, there is yet waiting to be dealt with an enormous mass of subjects relating to the personal welfare of the rank and file of the profession. We have been waiting patiently for years. As one candidate says: "the legislation of the past twenty years has decreased by one-third the earning powers of the general practitioner." Not legislation alone, but misapplied philanthropic effort. One candidate will "further the interests of those engaged in general practice." Another says "adequate remuneration," "fair payment for our services." This is the right sort, although these words do not go very far, in regard to method at least. But what stuff is this: "raise the standard of preliminary examination"; "a yearly tax on all who practise." We want men who will put, not their brain only, but their heart into the interests of the G.P. Those cases of old-age destitution, etc., we have referred to should be utterly impossible in five years' time, when our candidates return for our suffrages. On this occasion there is no pure consultant candidate. They have all passed through the mill. An immediately important question, it seems to me, is that of the provident dispensaries, many of which sadly want supervision. Only one candidate—perhaps two—puts this forward with definite clearness; others do not allude to it. To sum up, we want to represent us men who understand "the difficulties and trials, as well as shortcomings of everyday practice."

I am, Sir, yours very truly,

GEORGE CRICHTON, M.D.

114, Lexham Gardens, London, W.

WE are asked by the Hon. Secs. of Dr. Broadbent's Committee to insert the following:—

ELECTION OF DIRECT REPRESENTATIVES TO THE GENERAL MEDICAL COUNCIL, 1906.

TO THE REGISTERED MEDICAL PRACTITIONERS OF ENGLAND AND WALES.

Ladies and Gentlemen,—At the Quarterly meeting of the Medical Guild, Manchester, the following resolution was unanimously carried:—

"That this meeting warmly supports the candidature of Dr. G. H. Broadbent at the forthcoming election to the General Medical Council, and trusts that practitioners will do all in their power to secure his election. This meeting also entirely endorses the sentiments expressed and claims put forward by Dr. Broadbent in his address (MEDICAL PRESS AND CIRCULAR, Oct. 31st), and is confident that the interests of the profession may be well entrusted to his care."

Dr. Broadbent was nominated originally by the North Manchester Division of the British Medical Association, and his Committee appeal for your support on the following, among other grounds:—

1. That he has been engaged in general practice for upwards of 25 years, and his knowledge of medico-political subjects is such as to make him a a desirable representative.

2. That he has had special experience in medical politics as a member of the Central Ethical Committee, a representative at the annual Representative meetings since their inception, a member of the Lancashire and Cheshire Branch Council, Ex-president of the Incorporated Medical Practitioners'

Association, and a member of the Council of the Medical Guild since it began 14 years ago.

3. That he is opposed to Provident Dispensaries and disapproves of the profession undertaking any new contract work, and has always insisted on a wage-limit in all contract work.

On these grounds his Committee confidently appeal to General Practitioners all over England for their support and vote for Dr. Broadbent at the ensuing election. If you can see your way to allow your name to be added to his Committee, will you kindly notify,

Yours faithfully,

J. H. Taylor, M.A., M.B.,
Holly House, Salford.
R. G. McGowan, M.D.,
1, Thomas Street, Manchester.

THE DECLINING BIRTH-RATE.

To the Editor of The Medical Press and Circular.

Sir,—It takes some courage to stand up for an unpopular cause as your correspondent, Dr. Clement Sers. does. There may be evils and abuses in the limitation of families—there are in all good movements—but what does the movement show? Surely, that people are thinking for themselves, as Dr. Sers shows; that they are refusing to add to the twelve million who can barely exist under the present stress of life. Take my own county, for instance. Our able medical officer of health has just presented his annual report, and it tells the same tale that it has told for some years past—fewer births and fewer deaths. The birth-rate has fallen from 25.56 last year to 25.06 this, the birth-rate of England and Wales being 27.2. Against that set our mortality. The death-rate, like the birth-rate, is the lowest on record—namely, 14.32 per 1,000, as compared with 15.2 for England and Wales. In the present condition of things I hold that to be a result one can be proud of. Moreover, the total gain in population by lowering the death-rate is not counterbalanced by the loss through fewer births. Besides, with the lowered birth-rate goes a lower infant mortality rate, showing that *people are becoming more careful of human life*. That, to my mind, is a great gain to civilisation.

I am, Sir, yours truly,

Lancastrian.

Bury, Nov. 9, 1906.

INFANTILE MORTALITY.

To the Editor of The Medical Press and Circular.

Sir,—The experiment which the Mayor of Huddersfield initiated on taking office two years ago has produced the result which might safely have been predicted. No proof, to my mind, was needed of the fact that the excessive infantile mortality which prevails throughout the country is in great part preventable; but the experiment is none the less valuable as showing that the death rate can be reduced at once by one half by private effort, without the new legislation which is constantly demanded for the treatment of the social evils of this and similar kinds which afflict society at the present day. The Mayor's offer of a birthday gift of £1 to every baby born during his period of office, and surviving a year, was not intended as a stimulus to maternal care. The experiment was to see whether by constant watchfulness and help on the part of lady workers the death rate could not be reduced. The average rate during the previous ten years had been 122; whilst during the two years of the experiment it had been lowered, at the highest estimate, to 53. Infantile mortality is, of course, only a rough measure of the injury inflicted upon the populace by the causes to which it is due. For every baby dead there exist among the survivors large numbers with constitutions damaged by the period of malnutrition and illness through which they have passed—the halt, the lame, the blind, and the ricketty and "scrofulous" cripples who swell the army of unemployables and paupers which forms so terrible a burden upon the State. I trust, sir, that the ball set rolling by the Mayor of Huddersfield will have a long journey.—Yours truly,

Brighton. G. P. Londinensis.

OBITUARY.

ROBERT HAMILTON BELL, M.A., M.B., B.C (Cantab.), M.R.C.P., F.R.C.S.

The death of Dr. R. Hamilton Bell, of 27, Seymour Street, London, W., on October 29th, at the age of 35, is one of those tragic episodes that especially excite the sympathy of the members of our profession. That a man of great promise should be cut off at this early age and just as years of hard work and preparation seemed about to bring their well-deserved reward in the shape of an assured position and of professional success is indeed a matter for profound regret. And it may be truthfully said that Dr. Bell fell a victim to his assiduous devotion to his professional duties. Apparently a man of strong constitution, the strain involved in the constant attention he gave to those hospitals that claimed his services and the zeal with which he threw himself into all medical work combined to overtax his strength so that he was unable to fight the terrible acute disease which struck him down. A slight throat affection developed with startling rapidity into a double pneumonia of a low form, and to this he succumbed after a few days' illness.

Robert Hamilton Bell was educated at Trinity College, Cambridge, and at St. Thomas's Hospital, graduating in medicine in 1898. Devoting himself to obstetrics and gynæcology, he had been engaged in consulting practice for some five or six years, and was physician to out-patients at the Great Northern Central Hospital, at the Samaritan Hospital for Women, and at the British Lying-in Hospital. He was also obstetric tutor and Registrar at St. Thomas's Hospital, and examiner to the Central Midwives' Board.

Dr. Bell was a man of wide culture and sympathies, and was most popular with his hospital colleagues and professional brethren, and he has enriched the literature of his especial branch of medicine by several important contributions. Among them were papers on Puerperal Eclampsia, on Thyroid-like Structures in Ovarian Cysts, Torsion of the Pedicle in Hydrosalpinx and other morbid conditions of the Fallopian Tube, &c.

After but three years of married life he leaves a widow and one child to mourn his death, and many friends to grieve over the loss of a bright and charming personality and a trusted professional brother.

DUNCAN ROBERTSON, M.B., C.M.

We announce with sorrow the sudden death of Dr. Duncan Robertson, of Callander, N.B., on October 30th. Dr. Robertson went to his room to rest before going out in the evening, and on being called to see a patient was found dead in bed. Dr. Robertson was an M.B., C.M., of Edinburgh, and a little over forty years of age. He had been in practice in the district for about ten years. The early death of Dr. Robertson, so widely known as a skilful physician, and so universally liked for his genial character, is deeply regretted.

J. HAMILTON CRAWFORD, M.D.Edin., D.P.H.

We regret to record that the promising career of Dr. Crawford, of Bradford, was cut short on October 29th by death after an operation. Educated at Edinburgh, he took his M.B. and C.M. in 1891, and his M.D. with commendation in 1899. After being a demonstrator in pathology at Edinburgh, and a Demonstrator of Anatomy at Minto House School, he became house surgeon at Bradford Royal Infirmary. Settling in the town, he was elected assistant medical officer to that institution, and assistant surgeon to the Eye and Ear Hospital. Dr. Crawford was very popular with his colleagues, and his funeral was largely attended by members of the profession.

SPECIAL ARTICLES.

REPORT ON THE DUBLIN HOSPITALS.

In noticing the Annual Report of the Board of Superintendence of the Dublin Hospitals (*a*) we must, in the first instance, express our regret at the death of the Secretary of the Board, the late Dr. William J. Martin, who has edited the Report for many years, and whose courtesy made his intercourse with the officials of the various hospitals a pleasure to them.

The hospitals subject to the supervision of the Board are those in receipt of grants from Parliament, being nine in number. With their respective grants they are as follows:—Westmorland Lock, £2,600; Dr. Steevens', £1,300; Meath, £684 12s. 8d.; Cork Street, £2,500; House of Industry, £7,557 16s. 8d.; Rotunda, £700; Coombe, £200; Royal Hospital for Incurables, £250; and Royal Victoria Eye and Ear, £100. Only three of the institutions named, viz., Dr. Steevens', the Meath, and the House of Industry, are general hospitals.

The Board express general satisfaction with the management and condition of the hospitals throughout the year, and note that they have had no serious complaints to consider. They also comment on the marked improvement in the Dublin hospitals during the twenty years which have elapsed since Lord Aberdeen's first viceroyalty, and on the fact that the Dublin School has borne its full share in the advance of scientific medicine.

On April 1st, 1906, there were 957 patients in the hospitals under the supervision of the Board. The number admitted during the year was 11,601, making the whole number under treatment 12,226, of whom 11,052 left the wards either cured or relieved, or were discharged for other causes, and 469 died. 1,037 patients remained under treatment in these hospitals on March 31st, 1906. Exclusive of incurables, the mortality was 3.74 per cent. on those treated to a termination. The total daily average number of beds occupied in these hospitals throughout the year was 940.02. The time spent in hospital by each patient under treatment (omitting the patients in the Royal Hospial for Incurables) averaged 23.74 days.

In the three general hospitals inspected, the mortality on cases treated to a termination, the average number of beds occupied, and the average stay in hospital, were 4.14 per cent., 102.2 beds, and 24.69 days in Dr. Steevens'; 7.04 per cent., 103.45 beds, and 27.56 days in the Meath; and 6.83 per cent., 145.48 beds, and 26.75 days in the House of Industry.

The list of diseases treated in the various hospitals does not present many features of special interest. We note that typhoid fever is still prevalent in Dublin, 284 cases having been treated during the year, with a mortality of 31, or 10.9 per cent.; 11 cases of typhus were treated, without any death; there was no case of small-pox; there were 6 cases of tetanus, with 4 deaths.

The tables exhibiting the items of expenditure in the various hospitals present some remarkable contrasts. Thus, the average annual cost per bed for maintenance varies from £13 0s. 10d. in the Royal Hospital for Incurables, and £13 3s. 3½d. in the Lock Hospital, to £23 6s. 9¾d. in the Meath, and £24 12s. 4d. in Dr. Steevens'. Again, it is not easy to see why the expenditure on stimulants in the Coombe Lying-in Hospital, with an average of 32.3 beds occupied, should be £10 3s. 8d., while that in the Rotunda, with an average of 82.09 beds occupied, should be little more than half that sum—£5 14s.

The total expenditure on the nine hospitals under the Board amounted to £57,520 5s. 1d.

SLUMDOM IN LIVERPOOL.

We have received a reprint from a series of articles on this subject by the special commissioner of the *Liverpool Courier*.

The articles form interesting reading, and might, if properly brought out, have a practical outcome in good.

First of all comes the name Slum Trouble. The word "slum" is one savouring very strongly of Phariseeism, with a capital P., and probably no one but a Pharisee would ever think of making use of it. But we let that pass, as we know what it means, or what it means in the minds of those who make use of it. The writer states: "I must candidly admit that I commenced my investigations with a feeling that drink was the chief cause of the poverty. Perhaps it was only natural that I should incline to that view, because I am a lifelong teetotaller. . . . Be that as it may, my tour in the slums, prolonged on more than one occasion until after the public-houses were closed, has resulted in revelations which have certainly surprised me."

Although the commissioner does not profess to have solved the question of destitution and squalor that certainly exist, he has come to certain conclusions, as, for instance: "The overwhelming evidence of my investigations convinced me that misfortune—lack of work, casual labour, etc.—was the chief cause of poverty; and that utterly inadequate domestic arrangements constitute the principal reason for squalor." Lack of work is undoubtedly a main cause of the destitution. It may not be known everywhere that for dock work, in the loading and unloading of ships, the pay is good. This brings people to the city, and the docks are plentifully supplied with labour. But on the other hand, the work is very irregular, and often men will be unable to get more than one or two days' work a week. Good wages are therefore a snare in this case. They attract labourers who are doomed to disappointment, as they cannot get the work the pay for which tempted them. Two days' work a week at 4s. 6d. a day do not go far to support a family. So much for lack of work.

Inadequate domestic arrangements the Commissioner puts down as accounting for the squalor. This is in the main true, but it is not all the truth: the Irish Invasion, of which he speaks, accounts for a good deal of it. These people, we are told, came over to Liverpool in vast multitudes in 1847, the year of the potato famine. "By the end of June of that year more than 300,000 of these destitute peasants had arrived," and "it is calculated that 80,000 located themselves in Liverpool." We would like to quote further, but space forbids. The residue left stranded in Liverpool were naturally the most wretched and the least educated and intelligent. They were just as naturally those who were too helpless to move on. One may imagine the effect of the dumping of thousands of destitute people, who must live by work or other less honourable means, in a circumscribed area where work was not too plentiful before. It would simply swamp native labour. Besides this, the ignorance and squalor of these poor people acted as a blight that has not yet entirely passed away. Drink certainly plays a part, but the degrading ignorance of these classes contributes to it, as when a man's home is noisome and disgusting he will perforce seek solace elsewhere. But the subject is too big to pursue here, and we can only ask ourselves what is the remedy? The answer is not coddling, but education of the young, on whom alone rest our hopes.

REVIEWS OF BOOKS.

LABORATORY MANUAL OF PHYSIOLOGY. (*a*)

The increasing value attached to experimental work in biological science is one of the outstanding features of medical education at the present time. This particularly applies to the subject of practical physiology, which, as taught nowadays to the medical

(*a*) Forty-eighth Annual Report of the Board of Superintendence of the Dublin Hospitals, with Appendices, for the year 1905-1906. Dublin: H. M. Stationery Office. 1906.

(*a*) "Laboratory Manual of Physiology." By W. C. Busch, B.S., M.D. New York: Wm. Wood and Co. London: Bailliere, Tindall and Cox. Pp. lx., and 206. Illustrations, 47. Demy 8vo. Price 6s. net.

student, is becoming more and more the handmaiden of clinical medicine and clinical therapeutics. Nor can this tendency be considered as anything but beneficial both to medicine and physiology. To the former it brings disciples better prepared to apply the methods of scientific investigation to clinical work. To the latter it brings sympathy and incentive to work along particular lines, both of which are of great value to investigators in the subject.

In the preface to the work before us, which is described as "an outline of experimental physiology in brief and concise form," the author makes a claim which will be conceded by all, namely, that one of the main benefits to be obtained from laboratory work is the training in methods of exact observation.

Dr. Busch's book begins with an introductory study of one or two representatives each of the algæ, the fungi, and the protozoa. These are taken as types wherewith to illustrate the fundamental activities of animal and vegetable protoplasm. Amongst the flagellate infusorians is mentioned a trypanosoma found in frog's blood.

The following sections are then taken up in order :—(1) Muscle nerve physiology ; (2) nervous system ; (3) blood ; (4) circulation ; (5) secretion ; (6) digestion, absorption ; (7) respiration ; (8) excretion ; (9) sensation ; (10) vision.

The space allotted to each section shows that the balance is very evenly held between the different subjects. If the book be divided into twenty units of ten pages each, broadly speaking, four of these units go to experiments on the circulation, three units to muscle nerve physiology, two units to each of the sections on blood, secretion, respiration, and vision, while one unit is given to each of the remaining five sections, including the introduction.

The treatment of the individual subjects is also to be commended. All through, even in the chapters on muscle nerve physiology, experiments practically useful are selected in preference to those less applicable to everyday requirements, and this without sacrifice of educational value from the purely scientific standpoint. This is exemplified in the section mentioned, by the choice of experiments on the fatigue of human muscle, the stimulation of human nerves, the influence of load on the work of the muscle, the reaction of degeneration. As regards the latter, the experiment related, extremely instructive though it be, could not be performed in this country, even by a teacher of physiology, without the necessary legal permission. The book, however, is primarily written for the American worker.

The instructions for the performance of the experiments are certainly concise, but they border on scantiness ; evidently the author contemplated no lack of skilled assistants to aid the junior investigator.

From the standpoint of the British teacher of physiology, the work presents certain other striking features. The range of practical instruction in the branches of physiology of which the book treats is much beyond what could be demanded from or attempted by the medical student in this country under present conditions. But it must be at the same time admitted that there is hardly a superfluous exercise in the whole book, and that British students would gain immensely by having practised all of them. This programme, however, could not be carried out in Great Britain by any except holders of licences and certificates under the Act 39 and 40 Vict. c. 77. A large proportion of the experiments in all of the sections, and many of these the most instructive, are not otherwise permissible in this country. More is the pity ; for the student who systematically performs experiments on the anæsthetised frog, pigeon or rabbit, who puts into practice and studies the effect of removal of the pancreas or the thyroid from the dog, who investigates the effects of excitation and removal of parts of the cortex of the brain of the mammal, gets an insight into the functions of organs, otherwise unattainable, and at the same time learns operative technique in a way that can only be acquired by practice on the living being. The learner, however, in this country must count himself happy if he has had the opportunity of witnessing demonstrations of many of the most fundamental experiments here detailed which his American *confrère* can personally perform. Indeed, it must be confessed that few of the laboratories in this country are at present sufficiently equipped to enable any but a limited number of students to carry out the range of experiments here detailed.

Dr. Busch's book does not profess to cover the ground of physiological chemistry. This part of the subject has by many come to be regarded as a special one in itself. It has, however, to be borne in mind that physiology, and, indeed, biology generally, are becoming more and more chemical every day, and while one cannot restrict the ideal, teachers have to keep this point in view when planning courses of practical instruction for students whose time for a given subject is limited.

To sum up, the book is undoubtedly an admirable one, and British teachers will find in it a range of most useful and suggestive experiments from which to select, both for class work and lecture demonstrations. Many of them will also envy the superior opportunities of both teacher and student, who are provided with time and means for going systematically through the whole of this work.

THE KING'S CORONER.(*a*)

In Volume I., Mr. Henslowe Wellington devotes the first thirty-four pages to an historical outline of the office of coroner. As regards the origin of the office he suggests that it is at least as old as King Athelstan, since the word "coroner" occurs in the Charter of Privileges granted to St. John of Beverley in A.D. 925. It is, however, considered by the highest authorities on Saxon that the word "coroner" was inserted in the charter by a copyist at a period some two hundred and fifty years later.

The origin of the office certainly dates as far back as the Articles of Eyre, in A.D. 1194 (Richard I.), and there is evidence of its existence during the earlier reign of Henry II. The first printed edition of a statute containing the word "coroner"—as pointed out by Mr. Wellington—occurs in the Great Charter, A.D. 1225. We agree with the author that the statement made by some writers to the effect that the offices of mayor, chamberlain and coroner in the City of London were held by the same person is not tenable. Neither is it true that the Lord Mayor ever was, or is, *ex officio* coroner. Prior to A.D. 1478 the offices of king's butler, king's chamberlain, and coroner were held by one and the same individual. Mr. Wellington, following other writers, confounds the "king's" chamberlain with the City chamberlain—two entirely distinct officials.

The remainder of Volume I. is made up of a complete collection of the statutes relating to the office of coroner. This part of the work makes somewhat dry reading, but is, however, of historical interest as showing the gradual evolution of the office. The Coroner's Act, 1887, under which coroners of the present day carry out their duties, is supplemented by many useful footnotes. The frontispiece to Volume I. gives an artistic representation of the seal of the coroner of the king's household during the fourteenth century.

Volume II. contains chapters upon the practice and procedure before an inquest is held, upon the proceedings in court, and after the court has risen, with the necessary forms in swearing witnesses and in issuing orders, warrants, and other official documents. The opening chapter contains valuable matter, including a brief outline of the local constitution of the country in early times complementary to the historical sketch given in Volume I.

(*a*) "The King's Coroner: being the Practice and Procedure in his Judicial and Ministerial Capacities." By R. Henslowe Wellington, of the Middle Temple, Barrister-at-Law, Deputy Coroner for the City and Liberty of Westminster, &c., Lecturer on Medical Jurisprudence at the Westminster Hospital Medical School, M.R.C.S.Eng., L.R.C.P.Lond. In two vols. London: Bailliere, Tindall and Cox. Vol. I., pp. 292, 8s. 6d. Vol. II., pp. xvi-148, 7s. 6d. 1906.

The index in each volume is exhaustive, but the value of the work would, we think, be much enhanced by the provision at the beginning of each volume of a full table of contents, together with a table of cases cited. Mr. Wellington, under Part I., rightly enters somewhat fully into the important subject of "Procedure before the Inquest." This part of the coroner's work often gives him more responsibility than the actual holding of inquests, and is increased by recent Acts of Parliament, such as the Employer's Liability, Workmen's Compensation, Factory and Workshops, Infant Life Protection, Lunacy, Prisons, Fire, and other statutes.

Under Part II., which treats of the court and the procedure therein, the author says he knows of no definition of what constitutes "a body," so that the coroner must use his own discretion in holding an inquest on a portion of a body or on a mummy or in the case of still-birth. Mr. Wellington is silent as to the advisability or otherwise of the retention of the view of the body.

Mr. Wellington makes the unsupported statement that "It is not always necessary to have medical evidence at an inquest, so that the expense of calling it should not be incurred unless the coroner is satisfied that a skilled and scientific examination is necessary in order to determine the cause of death, or that it is necessary for the jury to have a history of the deceased's illness and treatment. We presume, however, by this he refers to those comparatively rare cases only in which the cause of death is self-evident—*e.g.*, in those seen deliberately to cast themselves into a river and be drowned, or seen to throw themselves from a height, or killed outright by means of a railway accident. But even in some of these cases medical evidence is advisable.

In Part III. mention is made of the unique power possessed by the coroner of the City of London to hold inquests in cases of City fires without loss of life. We think some expression of opinion might with advantage have been added with regard to the extension of like powers throughout London and to the large towns—at least, in England and Wales.

In the next edition a chapter might, with much practical advantage, be added on the subject of homicide. In such a chapter the legal definition and differentiation between the crimes of murder, manslaughter, and suicide might usefully be given, together with some account of other kinds of killing by neglect, accident or otherwise.

Altogether Mr. Wellington is to be congratulated on the results of his painstaking labours, and we would certainly recommend all those interested in coroner's work to avail themselves forthwith of the valuable summary of coroner's law contained in Volumes I. and II. of "The King's Coroner."

"CLINICAL DIAGNOSIS." (*a*)

So many excellent books on clinical diagnosis have recently been published that there seems little room for another, and this fact is admitted in the preface to the volume before us. The distinctive feature of the present work is that it considers clinical laboratory work from the clinical rather than from the laboratory point of view. The work is based on experience obtained during seventeen years of work carried out in the United States at the famous Johns Hopkins Hospital and University. Thus we find on going through the pages of this book that every fact stated is supported by clinical or other practical evidence. There are in all six chapters, covering some six hundred pages altogether. The first chapter treats of the sputum. Its appearance in various diseases is carefully indicated, the description of the sputum met with in asthma being one of the best we have yet seen. A beautiful coloured plate of the sputum got in cases of influenza has been inserted and has been admirably reproduced. One would imagine that the chapter on the urine could hardly contain anything new or striking, but this is far from being the case. The account given by the author of urinary pigments is specially complete and accurate. It is pointed out that the indoxyl-sulphate of the urine seems to bear some relation to the output of albumen, while it may indeed be of importance in relation to the early diagnosis of nephritis. The author finds it very valuable. When the reaction is present it is strong evidence in favour of typhoid fever. Glycosuria and acetonuria are given more than the usual prominence, and many less well-known but nevertheless important facts are introduced here for the first time into a text-book. Nearly thirty pages are given up to the consideration of albuminuria, and nothing of practical importance seems to have been omitted by the author.

In the third chapter—that dealing with the examination of the gastric contents—we find all that is best in American teaching on this subject referred to. In speaking of ulcer of the stomach Emerson incidentally refers to a clinical variety which he names the "vanitive" form. We do not like this word, even when it occurs in an American text-book. He sums up well the present position regarding the diagnosis of gastric cancer by laboratory methods when he says, "The chemical features may be very suggestive, in some cases normal, in some even the reverse of those suggesting cancer. At present we admit that age and clinical history are of far more importance than chemical examination." The chapter which treats of the intestinal contents and the fæces is short, but sufficient. Turning to that on the blood we are face to face with quite an array of interesting facts, many of which are extremely suggestive from the diagnostic and therapeutic points of view. The various methods of blood examination are explained in great detail, and the question of the diagnostic importance of leucocytosis in disease is very fully entered into, a list of conditions in which it occurs being given. The concluding chapter treats of the examination of various body fluids such as serum, cerebrospinal fluid, as well as the synovial and amniotic fluids. After a careful perusal of this work we consider it to be one of the best yet written on the subjects; it is well adapted to the needs of senior students and general practitioners who wish to keep themselves informed of modern advances in laboratory methods. It is also well printed and illustrated, and is supplied with a very copious index. No one who studies its pages can fail to derive fresh information and fresh ideas for clinical research.

(*a*) "Clinical Diagnosis": a Text-Book of Clinical Microscopy and Clinical Chemistry. For medical students, laboratory workers, and practitioners of medicine. By Charles Phillips Emerson, A.B., M.D., Resident Physician, The Johns Hopkins Hospital, Associate in Medicine, The Johns Hopkins University. Philadelphia and London: J. B. Lippincott Company. Price, 21s. net.

MOVABLE KIDNEY. (*a*)

THIS is one of the "Actualités Médicales" Series, published by Bailliere. In this small monograph, the author, who is well-known in the department of renal surgery, gives a clear account of the cause, symptoms, and treatment of movable kidney. He holds the view that movable kidney is merely the local manifestation of a general disease, a disease which shows itself in the nervous, the muscular, and the fibrous tissues of the body, the nutrition of all of these tissues being disturbed; in the majority of cases the mobility of the kidney is the first marked symptom. Numerous complications of movable kidney are discussed, clearly and with one exception briefly, for hydronephrosis caused by kinking of the ureter, when the kidney becomes displaced, is treated at considerable length, and deservedly so, since it is the most common, as well as one of the most serious troubles which occur in connection with this complaint. The author shows how difficult it may be to diagnose intermittent hydronephrosis. The condition when present nearly always requires operative treatment, and only in those cases in which the pelvis of the kidney is not greatly

(*a*) "Le Rein Mobile." (Movable Kidney). By Felix Legueu.

dilated is the condition likely to be relieved by merely fixing the kidney; where the pelvis of the kidney is dilated and deformed a uretero-pyelonostomy is alone likely to relieve the patient's symptoms. In most uncomplicated cases of movable kidney, the use of a suitable belt is sufficient, and only when this fails to relieve the pain, dyspepsia, and neurasthenia, is fixing the kidney advocated, Guyon's operation being the method advised. A full and clear description of the operation is included in this excellent contribution to renal surgery.

TOXINES AND ANTITOXINES. (*a*)

THE time had undoubtedly arrived when it became necessary to gather together into a single volume all the scattered and miscellaneous facts that have been discovered in connection with bacterial and other toxines and their antitoxines, and in making such a compilation Dr. Oppenheimer places the medical profession generally and all who are interested in the subject under a heavy obligation. The work can have been by no means of an easy nature, as in almost every case the original papers had to be consulted, and the number of these can be judged by a reference to the bibliography at the end of the volume. Indeed, if his labours had been confined to the mere collection of this reference list, no small service would have been rendered, as it is often difficult to discover the whereabouts of the original articles bearing on the less well-known toxines. The present translation now makes the book more accessible to the English reader, and as it has been brought thoroughly up to date, is even more useful than the German edition. In dealing with such a technical subject one would expect some stiltedness in the style of a translation; but this is not the case, for the whole book is most readable, and its diction excellent. The volume is divided into a general and a special part. The first deals with the general characters of toxines, including the methods of preparing them, and their general relation to antitoxines is discussed. In adopting a definition for the word "toxine," and a limitation to the subject of the book, Oppenheimer follows Erhlich, and excludes from the toxines "any poisonous substance that is not a haptine, and that does not produce an antitoxine." This limitation is very convenient, and has to be carefully borne in mind in order to understand and follow the terminology of the book. After dealing with the toxines, an excellent account of antitoxines, toxoids, and toxones concludes Part I. The second and special part of the work is divided into four sub-sections, dealing respectively with (1) the true toxines, of which the products of the diphtheria and tetanus bacilli are the most important, and in consequence receive the most space; (2) the endo-toxines; (3) the vegetable toxines; and (4) the animal toxines. Most of the sections and articles seem to be very complete, though one would have expected that a little more detailed information would have been given concerning the tubercular endotoxines. The account also of the typhoid poisons is not very complete, but having regard to the general scheme of the work, it is sufficient. On the whole, we regard the publication as a most important one, and think that it will soon be found indispensable in every bacteriological laboratory.

MARTINDALE'S EXTRA-PHARMACOPŒIA. (*b*)

OUR old friend the "Extra-Pharmacopœia," in this its 12th edition, manifests the disquieting tendency to obesity which one associates with advancing years. In truth, it is the only evidence of senility we can detect. In spite of the addition of some 250 pages, bringing the total up to 1,050, our friend remains "a dapper little gentleman," weighing only a few ounces, smartly attired and as prim as ever. The task of revision, in the hands of Dr. W. Harrison Martindale and Dr. Wynn Westcott, must be a task of ever-increasing scope, because, of course, the more text there is, the more is there to revise. The amount of valuable information between the covers of this small volume has always been of the nature of a surprise, and "the more we gaze the more the wonder grows." Apart from the numerous additions to, and modifications of, the pharmaceutical details and therapeutical applications of standard preparations and drugs, the authors have had to stem the tide of recent introductions, verifying their chemical status and pharmacology while so doing. The "supplementary list of drugs" occupies thirty pages of close print, and the chapter on anti-toxins and organo-therapeutic agents another fifty. The analytical memoranda have been extended to sixty pages, and so on; in fact, every department of practical medicine has been worked up to a high pitch of perfection. The index alone—a valuable feature of the book, is allotted upwards of a hundred pages. The outcome of it all is that Martindale's "Extra-Pharmacopœia" is more than ever before an indispensable *vade mecum* to the physician and practitioner, and we should pity the dispensing chemist who failed to place it in a foremost place among his works of reference.

(*a*) "Toxines and Antitoxines." By Carl Oppenheimer, M.D., Ph.D. Translated by C. Ainsworth Mitchell, B.A., F.I.C. London: Charles Griffin and Co., Ltd. 1906.

(*b*) "The Extra-Pharmacopœia of Martindale and Westcott. 12th ed. Pp. 1,045. London: H. K. Lewis. 10s. net.

BELFAST.

THE RECENT TYPHOID OUTBREAK.—The history of the recent outbreak of typhoid in one of the best residential districts of the city is now pretty complete, and makes most interesting reading, illustrating as it does the necessity for vigorous action on the part of the authorities at the earliest possible moment. The first case occurred on August 4th, or, rather, was reported on that date. For some reason suspicion at once attached to the milk supply, and the farm and dairy from which it came were inspected on August 7th, with negative results. Two more cases were reported on the 8th, one on the 10th, and two on the 14th, all among customers of this dairy. Inquiries were made as to sickness on the farm, with negative results. A sample of the milk was sent to Professor Symmers to test, again with negative results. Five more cases were reported in the next fortnight, and meantime the farm was again visited and the water supply examined. During September 14 cases were reported among the customers of the dairy, and various visits and inspections were made, but as no positive contamination was found, the sale of the milk still proceeded. On October 2nd and the dairyman, accompanied by his solicitor, attended at a meeting of the Public Health Committee and undertook to attend to the sanitation of the dairy very particularly, but refused to stop the milk supply to the city, as there was no evidence of its contamination. On October 6th it was reported that a positive Widal reaction had been obtained in the blood of a woman working in the dairy, and that no doubt she had lately suffered from typhoid. In consequence of reports appearing in the daily papers, the dairyman stopped the sale of milk about October 8th, but states, through his solicitor, that he does not admit that there was anything wrong with it. The whole history of the outbreak is instructive, and illustrates the limitations of the public health authorities. Here were about 30 cases of typhoid occurring in an otherwise healthy district, all among the customers of one particular dairy, and yet, for want of direct evidence that the milk was contaminated, its sale went on for about two months after attention was first directed to it. If the law allows no further powers to the local authorities than were exercised in this case, it is clear that it needs amendment.

MEDICAL NEWS IN BRIEF.

Royal College of Surgeons of England.

AT a meeting of the Council on Thursday last, Mr. Henry Morris, F.R.C.S. (President), in the chair, a letter was read from the Royal Commission on Vivisection, inquiring whether the College was desirous of nominating a representative to give evidence before them. The Council thereupon appointed the President of the College to give evidence. A fresh diploma of membership was granted to Dr. Winslow Anderson, whose diploma was destroyed by fire at San Francisco during the general conflagration in that city. The President reported that the Bradshaw Lecture would be delivered by Mr. Edmund Owen, F.R.C.S., on Wednesday, December 12th, at five o'clock, and that the subject of the lecture would be "Cancer: Its Treatment by Modern Methods." Professor Howard Marsh was elected the representative of the College on the Court of Governors of the University of Sheffield.

The Secretary reported that the following resolutions would be moved at the annual meeting of fellows and members, to be held at the College on Thursday next, the 15th inst.:—

To be moved by Mr. Joseph Smith:

That this twenty-second annual meeting of fellows and members again re-affirms the desirability of admitting members to direct representation on the Council, which as now constituted does not represent the whole corporation.

To be moved by Dr. W. G. Dickinson:

That this meeting recommends that, when the question of admitting women to the College examinations is brought before the fellows and members, this should be done either by means of a corporate meeting or by poll of the fellows and members, inasmuch as the meetings as hitherto held under the regulations of the Council have no authority to determine any question whatever, and their resolutions on other subjects are almost invariably disregarded by the Council.

To be moved by Dr. A. S. Morton:

That in pursuance of their resolution in July last, the Council is hereby requested to make further representations to the Government urging the necessity of amending the Midwives Act next session, in order that provision may be made to secure just remuneration for professional services rendered by medical men under that Act.

To be moved by Mr. George Brown:

That, in view of the overcrowding and straitened circumstances which exist in the profession, this meeting strongly urges the Council to use all its influence to secure the raising of the standard of the preliminary examinations in general education and in science; and this meeting is further of opinion that the time has arrived when chemistry, physics, and biology should be treated as matters of preliminary education, and an examination passed in them before the commencement of medical studies.

The Malthusian League.

AT a largely attended conversazione held at the Finsbury Institute on Thursday last, Dr. C. R. Drysdale delivered an address on the rise and progress of the movement in this country and abroad. He rejoiced that the birth rate in Great Britain had been steadily declining for many years, and that the middle classes were now practically Neo-Malthusians as a body. This, he remarked, is continually being deplored by our Empire-makers; but they do not seem to be aware or the fact that in the same time the death rate has almost steadily declined from 21.6 to 16.2 per 1,000, which should be some compensation. He was convinced that this fall in the death rate is almost entirely due to the reduction in the birth rate, and this view is supported by any comparison which may be made between different countries and different localities. We still increase at the rate of half-a-million yearly, or 1,300 a day, and most of our own legislators have at one time or another admitted the gravity of the question. He considered that the time had now come for the movement to enter on a new stage, and to ask for recognition and discussion in Parliament.

Striking Reduction of Infantile Mortality.

LAST week, in quitting office as Mayor of Huddersfield, Alderman B. Broadbent referred to the result of the experiment which he began at the beginning of his term of office, and which was now complete. The first baby to whom he promised the birthday gift of 20s. was born on November 10th, 1904, and the last on November 8th, 1905, which received its birthday present on that day. During the last ten years the average infantile death rate was 139, and in Longwood (the district where the experiment was tried) for the same period the figures were 122, and the experiment was to see whether, by constant watchfulness and help on the part of lady workers, the rate could not be reduced. His promise of a birthday gift was not intended as a stimulus to maternal affection or care. He had staked £100, and had gained the end at which he aimed. Throughout the two years the conditions had been by no means favourable, as whooping cough and measles had been very prevalent, and 1906 was one of the deadliest years on record; 112 babies were born, and of those 107 had actually received the gift he offered. Four of the 112 had died, and one had left the district and could not be traced. Counting only four as dead, the mortality figure was 35, but counting five it was 44, or counting six, due to the overlapping of the periods, the figure would be 53; so that the infantile death rate for the experiment was reduced substantially to less than one-half the average rate, and put into percentages the result would be 54, 61, or 69. The reduction, therefore, was not only appreciable, but it was striking.

Army Medical Reserve of Officers.

A ROYAL warrant included in this month's Army orders amends the constitution of the Army Medical Rerserve of Officers, and substitutes new provisions for the pay, appointment, and promotion of officers.

Under these commissions as lieutenants in the Army Medical Reserve may be given to persons, not over thirty years of age, who may be duly qualified under regulations approved by the Army Council. The ranks of officers of the Army Medical Reserve shall be those of captain and lieutenant, and the total period of service in the Reserve shall be limited to seven years. On the completion of three and a half years' service a lieutenant shall be eligible for promotion to the rank of captain, if recommended for that rank.

Appointments to commissions will be made on probation, and persons so appointed will undergo an initial training of two months, on the expiration of which, should their work and conduct be considered satisfactory, their commissions will be confirmed.

When called to Army service, or while undergoing training, officers of the Reserve shall receive the pay and allowances of officers of similar rank in the Royal Army Medical Corps. After the first year's service an officer shall, in addition to any such pay and allowances for days of actual service, receive pay at the rate of £20 a year. This rate shall be increased to £25 a year if the officer is promoted to the rank of captain.

Officers of the Army Medical Reserve constituted by this warrant shall be liable to be called to Army

service at home or abroad at a time of emergency, and shall also be subject to the general regulations applicable to Army Reserve officers. The sum of £5 will be allowed towards the provision of uniform.

Sent to Goal.

Dr. Edward John Havens, a retired medical practitioner, who has resided at Clacton-on-Sea for some years, was charged at Thorpe Petty Sessions, on the 5th inst., with wilfully obstructing a lad on a bicycle on the Electric Parade, and also with damaging a chair on the promenade belonging to the Clacton Urban District Council. It was stated that as the lad was riding past him defendant put out his foot, causing the boy to fall from his machine. With regard to the damage—which was done some days later—defendant mounted a heap of chairs and threw some over the cliff. Defendant had been before the Court several times previously for extraordinary conduct, the last time for firing a loaded revolver in the street on a dark night. For damaging the chairs he was fined £4, and for obstructing the cyclist he was sent to prison for seven days, without the option of a fine.

Death from Lock-Jaw in Newcastle.

Touching the death of Mr. David Key, of Blyth, who died recently at the Royal Victoria Infirmary, Newcastle, an inquest has since been held. Thomas Blackett, of Blyth, said that the deceased, while walking down his garden-path on October 25th, stepped unawares on to a nail in a plank which was lying across the pathway. The nail penetrated the sole of his left foot, and was with difficulty withdrawn. Mr. Keys was medically treated, but the condition of his foot became so serious as to necessitate his removal to the Infirmary. Dr. Cunningham, house surgeon at the institution, said that when Mr. Keys was admitted to the Infirmary tetanus had already set in. Gradually it developed and caused his death. The small wound in his foot showed signs of having been caused by a rusty nail. A verdict in accordance with the medical testimony was returned.

Dinner of the Irish Medical Schools' and Graduates' Association.

The autumn dinner of the Irish Medical Schools' and Graduates' Association will take place at the Hotel Great Central, Marylebone Road, N.W., on Wednesday, November 28th, at 7.30 p.m. The guest of the Association will be Admiral of the Fleet Sir Edward Seymour, G.C.B., O.M. Tickets can be obtained by members of the Association from Mr. Canny Ryall, F.R.C.S.I., 85, Harley Street, London, W.

Death under Chloroform at Liverpool.

The Liverpool City coroner held an inquest, on November 1st, on the body of Martin M'Nulty, æt. 31, a boiler-scaler. M'Nulty had received injuries in the course of his employment some months ago, and had to undergo an operation. On Wednesday it was found necessary to operate upon him for rupture. Chloroform was administered, but before he had had enough of the anæsthetic for the operation to be performed, his breathing became embarrassed, and despite every possible effort he died in about twenty minutes. The jury found that death was due to syncope, and that the chloroform was skilfully and properly administered.

Vital Statistics.

The deaths registered last week in the eighty great towns of the United Kingdom corresponded to an annual rate of 15.4 per 1,000 of their aggregate population, which is estimated at 17,740,164 persons in the middle of this year. In the preceding three weeks the rates had been 15.5, 14.6, and 14.6. Measured by last week's mortality, the highest annual death-rates per 1,000 living were:—from all causes, 23.7 in Dublin, 20.0 in Birkenhead, 20.1 in South Shields, 20.2 in Preston, 20.3 in Warrington and in Sunderland, 20.8 in Liverpool, 21.9 in Middlesbrough, 22.0 in Hanley, 23.7 in Oldham, and 19.2 in Glasgow; from measles, 2.2 in Oldham, 3.0 in Rochdale, 3.2 in Bootle, 3.3 in South Shields, 3.8 in Warrington, 4.3 in Rotherham, and 4.9 in Norwich; from scarlet fever, 1.6 in Wolverhampton; from diphtheria, 1.3 in Aston Manor and 1.5 in Ipswich; from whooping-cough, 1.6 in Middlesbrough; from "fever," 1.5 in Warrington; and from diarrhœa, 2.6 in Rotherham, Middlesbrough; 3.3 in Oldham, and 4.9 in Preston. No death from smallpox was registered in any of the eighty towns.

Death under Chloroform at Halifax.

Mr. E. W. Norris held an inquest at Halifax, last week, on John Wood, 55 years of age, who died under chloroform at the Nurses' Home on Sunday. Evidence having been given to show that the chloroform had been properly administered, the jury returned a verdict of "Death from misadventure."

PASS LIST.

Royal College of Surgeons, England.

The following candidates, having passed the required examinations and conformed to the by-laws, were admitted members of the College on Thursday last:—E. H. Adams, E. Alban, E. Balthasas, A. L. Baly, G. B. Bartlett, H. G. Bennett, A. W. Berry, M. Birks, P. Black, H. O. Blandford, L. H. Bowkett, J. E. M. Boyd, G. G. Butler, W. E. Carswell, C. Cassidy, J. B. Close, A. G. Cole, H. G. Cole, I. R. Cook, J. Couper, S. Barrett, P. P. Daser, H. R. Davies, G. H. Dive, F. C. Doble, L. Doudney, S. F. Dudley, A. G. Dunn, L. Edwards, R. R. Elworthy, D. Embleton, C. H. J. Fagan, J. S. Farnfield, C. H. Fernis, P. Fiaschi, R. D. Forbes, W. Gabe, R. F. Gerrard, S. W. Grimwade, J. R. Gunne, E. H. R. Harries, T. S. Harrison, T. S. Hele, D. W. Hume, R. W. Ironside, T. J. Jenkins, D. M. Keith, T. Ll. Kenion, W. R. Kilgour, W. H. King, C. Lebon, W. H. Lee, R. D. Low, J. A. McCullum, O. R. McEwen, P. D. F. Magowan, E. S. Marshall, J. D. Marshall, D. Manekji Masina, E. W. Matthews, H. B. Maxwell, C. A. L. Mayer, F. E. W. Meadows, O. Le F. Milburn, S. W. Milner, H. V. Mitchell, W. S. Mitchell, E. Morgan, R. J. Mould, L. D. Neave, F. M. Neild, R. B. Nicholson, H. J. Nightingale, T. Norman, H. W. Ogle-Skan, M. W. B. Oliver, G. G. Packe, G. S. Parkinson, E. H. A. Pask, G. D. Perry, G. R. Phillips, A. J. S. Pinchin, A. M. Pollard, E. S. Prior, A. E. Pryse, R. M. Rendall, A. T. Rivers, P. M. Roberts, R. C. Roberts, I. J. Roche, T. R. St. Johnston, C. N. Slaney, H. A. Smith, F. M. W. South, H. McL. Staley, P. K. Steele, A. C. H. Suhr, D. W. Tacey, O. Teichmann, H. E. H. Tracy, F. C. Trapnell, W. H. Trethowan, C. Tylor, I. Valerio, J. P. Walker, S. L. Walker, C. G. Welch, C. E. Whitehead, R. H. Williams, W. S. Williamson, H. D. H. Willis-Bund, J. G. Willmore, J. L. Wood, E. M. Woodman, H. N. Wright, A. B. Zorab, C. E. Zundel.

Trinity College, Dublin.

At the Michaelmas Term, 1906, the following candidates passed the intermediate Medical Examination, Part I.:—R. T. Brooks, J. P. S. Dunn, G. E. Craig, R. D. FitzGerald, W. H. Hart, J. E. M'Causland, W. R. Allen, J. Alston.

Preliminary Scientific Examination.—The following passed in *Physics and Chemistry*:—Dorothea M. Franks, F. J. A. Keane, S. R. Richardson, C. D. Hanan, M. S. Moore, T. G. Hardman, P. F. Nunan, J. W. Flood, V. W. T. M'Gusty, John G. Dods, Hans. Fleming C. J. Pentland, F. Crosbie, E. F. Lawson (Sch.), and E. Garland.

Botany and Zoology.—Mary G. Caskey, M. S. Moore, T. G. Hardman, W. O. Halpin, J. B. Burgess, F. R. Dougan, R. G. M'Entire, L. F. Macan, H. E. Williams, F. Casement, H. L. Blackley, G. F. C. Healy, H. G. G. Holdbrook, T. F. Preen, S. A. Lane, S. A. Dudley, and R. T. Vaughan.

Final Medical Examination, Part I.—J. B. Jones, J. G. M. Moloney and T. Ryan (equal), J. R. Yourell, F. Seymour, H. P. Hart and E. Jameson (equal), T. P. S. Eaves, J. D. K. Roche, W. Knapp, J. P. R. Poch, T. P. Dowley and G. A. Jackson (equal), B. A. H. Solomons.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS. ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT SURGICAL SUMMARY.

The Operative Treatment of Acute Gonorrhœal Epididymitis.—In recommending the operative procedure, Haynes (*Medical Record*, October 13th, 1906) draws attention to the pathological reports of Monod and Terrillon. They find that:—(1) In gonorrhœal diseases of the testicle the epididymis only is involved. (2) There is marked dilatation of all the tubes of the epididymis, the result of obstruction, which is due to the pressure caused by the infiltration of inflammatory exudation into the connective tissues surrounding the tubules. (3) Such obstruction may lead to degeneration of the seminiferous tubules, with resulting atrophy of the testicle. The author admits that most cases of epididymitis will recover with only medical treatment, but severe cases will not recover as rapidly or with as little apparent anatomical disorganisation as when operative procedure is employed. This is as follows:—An incision through the scrotum down to the tunica vaginalis is made at the junction of the swollen epididymis and testicle. The tunica vaginalis is opened in the same line, and the testicle delivered from it. Numerous punctures are made in the fibrous covering of the epididymis with a tenetome, these being deep enough to enter the infiltrated connective tissue. The tension under the thickened covering of the epididymis is markedly lessened. If pus escapes from any of the punctures, the opening is enlarged, and a small probe passed in the direction from which the pus flows. The cavity is syringed out. The testicle is restored into the tunica vaginalis, which is also thoroughly washed out. The wound is then closed with a cigarette drain of gauze at its lower angle. In every case operated on by the writer fluid resembling that found in gonorrhœal joints was found in the tunica vaginalis. In three out of the six cases pus was found in the epididymis. The globus minor was mostly affected. The relief following the operation is immediate, and seems to be just as great whether pus is found or not. The author concludes that operation is a rational procedure according to known pathology, and the danger to the patient is slight. The infiltration of the epididymis disappears more rapidly with this treatment than with any other. The danger of permanent injury to the organ is lessened. Patients are absolutely relieved from pain on recovery from the anæsthetic. The systemic symptoms are promptly relieved. S.

Some Principles of the Treatment of Fracture.—Bowser (*Brit. Med. Journ.*, October 27th, 1906) discusses the important modification which has been introduced during recent years into the treatment of fractures. This consists principally in the early employment of massage and movement, and in a less absolute adherence to the traditional methods of immobilisation. Prolonged immobilisation attends too exclusively to the solution of continuity of the bones, and neglects the associated injuries of the soft parts. As is seen in broken ribs, absolute immobility is not essential to bony repair. In certain cases immobilisation is necessary to prevent displacement only, and even in these cases experience shows that the length of time it is employed may be materially shortened. Wasting of the muscles, stiffness of the joints, weakness of the limb, and pain on attempting movement, are the common disabilities, which are, in reality, not due to the fracture, but to the treatment by immobilisation. Dissections have shown that intra-articular adhesions, fibrous ankylosis, erosions of cartilage, and various other injuries to the joint structures have resulted from the long-continued immobilisation of joints previously healthy. The bones, muscles, motor nerves and nerve centres themselves are differential parts of one organ of motion, and lesions of one induce lesions of the other. Therapeutic measures should take account of them all. Early massage and movement enables us to avoid many of the unfavourable results of immobilisation, and it is estimated by Bennett that the time that requires to elapse before a patient is permitted to resume his ordinary occupation is diminished by one-third. The massage employed differs from that of a professional masseur. It consists of a soft, smooth, uniform, and, above all, painless mobile pressure in the direction of the venous current. Ordinarily, massage is practised from the very beginning of the treatment, and repeated daily in séances of half-an-hour's duration. Massage prepares the way for movement. After massage, passive movements of the joints, which before had been impossible on account of the pain that they caused, become surprisingly easy. These movements, whether passive or active, are necessarily of slight extent, being limited by two imperative conditions—they must be painless, and they must not cause any new displacement of the bony fragments. The most striking results of massage are the relief of pain, the relaxation of muscular spasm, the removal of swelling, the maintenance of flexibility of joints and tone of the muscles. Kocher recommends the form of muscular exercise consisting of the voluntary contraction of muscles in certain fractures. S.

Cases of Pott's Disease, and of Coxalgia, Presenting Unique Features.—Rugh (*Med. Record*, October 13th, 1906) reports the following cases:—CASE 1.—Miss M. W., æt. 71, has good family and personal medical history. In May, 1903, she commenced to suffer from pains in the stomach. In June, 1903, she developed weakness in both legs, and difficulty in walking. She was treated in a hospital for three months, at the end of which time the patient was able to walk again. In November she was obliged to return to bed, and a small knuckle appeared in the dorsal region involving the 8th and 9th vertebræ. In April, 1904, spasmodic contractions of the legs and feet began, followed shortly afterwards by incontinence of the bowels and bladder. Patient improved somewhat by treatment in hospital, but eventually began to fail, and died in March, 1905. No abscesses had formed, but paralysis became complete before her death. The case is interesting on account of the development of primary tuberculosis of the spine in a woman of over 70, with no apparent causative history; also on account of the early and rapid onset of paralytic symptoms even before the appearance of the knuckle in the spine. CASE 2.—J. M., æt. 50, had no previous tuberculous history. In 1903 both testicles were removed for tubercular disease. In 1904 patient complained of pain in the stomach, as in Case 1. At this time a small prominence formed over the 7th, 8th, and 9th dorsal vertebræ. Patient improved with treatment. In May, 1905, patient complained of pain in the legs and lower part of the abdomen, and was found to have a tuberculous kidney. In May, 1906, the writer removed portion of the laminæ of the 7th dorsal vertebræ. The wound healed by first intention, and the patient left hospital with a spinal support. He was much improved and apparently on the way to complete recovery. CASE 3.—A man, æt. 38, is of interest as showing the extremely slow onset of Pott's disease. In spite of heavy work being constantly engaged in by the patient, without any form of mechanical support or treatment for his disease, seven years elapsed before he was forced to give up work for the first time. Since treatment has been begun the patient is progressing very favourably. CASE 4.—J. J. M., æt. 72. When eight years of age (1837) contracted hip disease. He was treated by George McClellan, at that time Professor

of Surgery to Jefferson College. Abscesses developed later, and were opened by Dr. McClellan. When he was 12 years old (1841) the abscesses healed and the hip was ankylosed. He grew to manhood, followed his trade, married, and reared a family. In 1901, when the patient was 72, without any known injury or cause, pain began in the hip and thigh. A few days before presenting himself at hospital, three of the old sinuses reopened. When seen by the writer, the sinuses were discharging purulent matter in every way similar to tuberculous pus. The character of the sinuses and pus, and the manner of onset, left no doubt in the author's mind that it was a re-lighting of an old process from which the patient had apparently recovered sixty years previously. S.

Indications for Surgical Intervention in Diseases of the Stomach.—J. Blake (*New York Medical Journal*) calls attention to the limits and uses of gastric surgery, and points out that gastric surgery is more hindered than helped by a mistaken idea of its possibilities. Operations may be divided into three main procedures: First, repair of wounds and perforations; second, improvement of drainage; and third, partial excision. The indications for the surgical treatment of any condition depend upon whether it will be benefited by one or more of these procedures, and whether the benefit is commensurate with the risk. In the first place the indications for operation are clear, in the second class the author asks for a more frequent surgical treatment of ulcer of the stomach, and gives a series of excellent results obtained by gastro-entersostomy in such cases. In the third class of cases, if we wait until we can say with certainty, "this patient has gastric carcinoma," in most cases it will be too late to operate. We must, then, determine on a set or group of symptoms which, when present, will indicate an operation, although they are not diagnostic of any one condition. Operation should never be refused, where there is a chance of benefit, particularly in those cases where the drainage of the stomach is interfered with. G.

On Access to the Knee Joint.—H. Russell (*Intercolonial Medical Journal*, August, 1906) describes a method of exposing the knee joint by means of a longitudinal incision carried from a point two inches above the patella across the middle of this bone to a point about two inches below it. When the soft parts are divided the knee is partly flexed and the patella sawn into two halves by a longitudinal saw-cut down into the joint, the divided halves are pulled to either side, the joint completely flexed, and in this way thoroughly exposed to the operator; when the joint has been dealt with the leg is straightened and a catgut sature passed above and below the divided halves of the patella to prevent the bone separating; the skin is then closed in the ordinary way. The advantages of this method are: Avoidance of need for wiring the patella; avoidance of even that temporary impairment of the strength of the patella, or any other of the joint structures; more perfect access to the lateral recesses of the joint, and supra-patellar pouch, than can be obtained by any other method.

A Fatal Case of Scopolamine Poisoning.—G. Ely reports (*New York Medical Journal*, October 20, 1906) the case of Mrs. T., aged 29, suffering from carcinoma of the larynx; heart, lungs and kidneys were normal, she was considered a suitable subject for the administration of scopolamine; accordingly, at 6.30 a.m., she was given hypodermically $\frac{1}{4}$ of a grain of morphine, and $\frac{1}{100}$ of a grain of scopolamine. Contrary to instructions, the patient rose from her bed and moved about for half an hour, and then lay down, falling at once asleep; soon after she became slightly cyanosed, and her breathing markedly stertorous, mouth dry, surface of the body pale and dry, the superficial reflexes were abolished; all attempts at rousing her failed, respirations became shallower, and two hours after the administration of the drug the patient died from respiratory failure. That death was due to the administration of the drug alone seems to be almost certain, as her organs had been examined by several different physicians and found to be normal.

The Surgical Treatment of Aneurism.—R. Lozano reports (*American Medical*, September, 1906) five cases of aneurism treated by the intra-saccular method of suture, as devised by Matas, of Orleans. From these cases the author draws the following conclusions: (1) That this method will cure aneurisms as radically as the method of extirpation. (2) This method of suture is exempt from the majority of post-operative complications, which usually follow the classical methods of treating aneurism, and for the control of hæmorrhage. (3) This method of suture can be applied to all aneurisms that are surgically accessible in any part of the body, whereas the method of extirpation is not practicable with safety in all regions of the body. (4) The method of intra-saccular suture is the most favourable for the preservation of the collateral circulation, as this is not disturbed in any way by suturing the orifices of the vessels inside the sac. (5) The method of intra-aneurismal suture is the only operative procedure which offers any prospects of radical cure in the treatment of abdominal aortic aneurisms. (6) The advantage intra-aneurismal suture has over the ligature is that it offers a stronger, more resisting barrier to the bloodstream above the line of obliteration, and is thus much less liable to secondary hæmorrhage than the ligature, which has invariably failed in every case of abdominal aneurism operated by ligation up to the present time. G.

The Making and Dressing of Wounds.—M. F. Porter says (*American Medical*, September, 1906) it is an easy matter to overdo the attempt to render the skin or an accidental wound aseptic. Buried sutures are advocated wherever possible, for buried sutures are less likely to be a source of infection than through and through sutures are. Sutures, re-dressings, and drains are necessary evils, hence all sutures should be discarded in favour of the bandage and adhesive plaster when these can be made to serve the same purpose, but when the use of sutures is imperative, then buried absorbable sutures should be preferred, buried non-absorbable temporary sutures should be our second choice; through and through sutures should be only used on compulsion, and buried permanent sutures discarded except in work on the hollow abdominal viscera. Our aim should be to do the first dressing so that it will be the only one needed, until healing is accomplished, and where this is impossible our efforts should be directed towards preventing the necessity for frequent dressing. When in doubt, do not drain, but if drainage is imperative, let it be adequate without being harmful, kept up while it is needed, and discarded as soon as it has fulfilled its mission. G.

Infection of Corneal Wounds by Saliva.—G. Hotta (*Klin. Monatsbl. f. Augenheilk*, September, 1905) experimented on rabbits, cats, and mice by inoculating saliva of persons of various ages and classes into their corneæ. Three kinds of wounds were made, viz., abrasions, pocket wounds in the corneal lamellæ, and perforating wounds. After twenty-four hours cover glass preparations from the wounds were made and cultures taken, the media being neutral agar, glycerine agar, Löffler's blood serum, and bouillon incubated at 35 deg. C. Ninety experiments were made, with the following results. The thirty perforating wounds gave negative results. One of the thirty abrasions was positive. All the pocket wounds were positive. These last cases developed iritis, hypopyon, and circumcorneal infection. Of the thirty pocket cases, pneumococci were detected 11 times, streptococci 17 times, staphylococci 9 times, and tetragenus 5 times No cultures were noticed in six of the cases. Hotta considers that muslin veils are quite effectual in preventing infection from the operator's mouth, although they are not an absolute preventative against spraying of the saliva. The possibility of infection seems so remote, although possible, that Hotta believes the veil to be unnecessary. M.

NOTICES TO CORRESPONDENTS, &c.

☞ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to 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 proofs.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions, the same rule applies as to office; these should be addressed to the Publisher.

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.

SUBSCRIPTIONS.

SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance.

NESCIENS.—(1) Yes. (2) Albuminuria, sometimes accompanied by a certain degree of cardiac dilatation, has been observed after hard exercise. Casts and blood have also been reported. (3) See "Munich. Med. Wochenschrift," 1906, Vol. III.

R. T.—From a table before us, which seems well grounded, we can supply the following figures:—171 cases with history of rheumatism, and 618 cases without such history. Of the former 34·5 per cent. showed cardiac lesion, of the latter 16·9 per cent.

MORS.—A prize for the discovery of an infallible test of death was offered as long ago as 1868 by the Marquis of Ourches, a French nobleman. The sum was £1,000, to be reduced to £500 if the test were only applicable by medical men.

KING STREET.—We believe the agency has long since died out. We cannot trace it later than 1887. But there are plenty of good modern ones.

W. H. T.—Sodium Salicylate is for the most part excreted in the urine salicyluric acid, a combination with amido-acetic acid.

SQUAMOUS.—We fancy that Scotch children will bear comparison with any as regards physique. Certainly they are not likely to be beaten by the French. See a recent address given by Professor Graucher before the Academy of Medicine, Paris. He found on examining 4,226 elementary school-children that some 15 per cent showed more or less definite signs of tuberculosis.

Dr. T. (Sheffield).—There is no satisfactory way of judging of the properties of preparations, unless they have been standardised. In the case of strophanthus—as in that of digitalis—physiological standardisation is the only trustworthy method. Several of the larger firms supply physiologically standardised preparations, and it is just as well to insist on having them.

M.D.LOND.—The election results were communicated to Convocation on October 9th. Dr. Gordon Little was elected.

RELATIVE POPULATIONS.

AN ACTUARY.—Your enquiry should have been addressed to the Registrar-General's Office. However, as we have the figures before us from the official source we give you them as follows:—London (not including the suburban area), 4,721,217; Glasgow, 835,625; Liverpool, 739,180; Manchester, 637,126; Birmingham, 548,022; Leeds, 463,495; Sheffield, 447,951; Dublin, 378,994; Belfast, 366,220; and Edinburgh, 341,036. If you wish to take Greater London into your calculations the latest returns give the population as 7,113,561.

MR. B. L. C.—We do not profess to unravel puzzles: the point is a nice one. Write to the office of the General Medical Council.

TU QUOQUE (Leeds).—On inquiry we find that the book is out of print. Perhaps a copy could be obtained through a second-hand bookseller.

ANTE-DATE.—We should advise our correspondent to consult a solicitor.

M.R.C.S.—A book, little read now, Hilton's "Rest and Pain," would probably give our correspondent the information he wants.

DR. PRINGLE.—We hope to have space for your communication in our next. Mr. Stewart Johnson's letter came to hand as we were "at press," too late for present issue.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, NOVEMBER 14th.

HUNTERIAN SOCIETY (London Institution, Finsbury Circus, E.C.).—8.30 p.m.: Discussion on Gonorrhœa. Short Papers will be read by Dr. L. Smith, Dr. E. Michels, and Dr. R. Andrews.

DERMATOLOGICAL SOCIETY OF LONDON (11 Chandos Street, Cavendish Square, W.).—5.15 p.m.: Meeting.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. J. Pardoe: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. A. H. Tubby: Surgical Diseases of Children.

THURSDAY, NOVEMBER 15th.

ODONTOLOGICAL SOCIETY OF GREAT BRITAIN (20 Hanover Square, W.).—5 p.m.: Demonstration: Prof. W. D. Miller: Some Observations and Experiments on the so-called Erosion of the Teeth.

MEDICO-PSYCHOLOGICAL ASSOCIATION OF GREAT BRITAIN AND IRELAND (11 Chandos Street, Cavendish Square, W.).—3 p.m.: Papers:—Dr. R. P. Smith: The International Congress on the Care of the Insane held in Milan last September. Dr. R. W. Branthwaite: Drunk and Disorderly. Dr. P. Stewart: Diagnostic Value of Examination of the Cerebro-spinal Fluid.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. J. F. H. Broadbent: The Diagnosis and Treatment of Duodenal Ulcer.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Mount Vernon Hospital, Hampstead).—5 p.m.: Demonstration: Dr. J. E. Squire: Cases of Chest Disease.

FRIDAY, NOVEMBER 16th.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN (11 Chandos Street, Cavendish Square, W.).—5 p.m. Cases will be shown by Dr. E. I. Spriggs; Dr. T. R. Whipham, Dr. F. Cautley, Dr. Carpenter, Dr. Hawthorne, Dr. J. F. Parkinson, and others. Paper:—Dr. J. Burnet (Edinburgh): Psoriasis in Childhood.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.:—Mr. R. Lake. Clinique. (Ear.)

Vacancies.

Gloucester County Asylums.—Junior Assistant Medical Officer. Salary £150 per annum, with board, apartments, and washing. Applications to the Medical Superintendent.

Dorchester County Asylum.—Junior Assistant Medical Officer. Salary £140 per annum, with board, lodging, &c. Applications to the Medical Superintendent.

Barnsley Hall Asylum, Bromsgrove, Worcestershire.—Senior Assistant Medical Officer and Deputy Medical Superintendent. Salary £200 per annum, with furnished quarters, board, washing, and attendance. Applications to the Medical Superintendent.

Aberystwyth Infirmary and Cardiganshire General Hospital.—House Surgeon. Salary £150 per annum, with board and residence. Applications to R. T. Edwards.

Saint George's Union, London.—Second Assistant Medical Officer. Salary £120 per annum, with board, residence, and washing. Applications to the Clerk to the Guardians, St. George's (Hanover Square) Hall, Mount Street, London.

Palmer Memorial Hospital (for Accidents), Jarrow-on-Tyne.—House Surgeon. Salary £150 per annum, with board and residence. Applications to Andrew W. Young, Secretary.

Saint Andrew's Hospital for Mental Diseases, Northampton.—Third Assistant Medical Officer. Salary £150 per annum, with board, lodging, and washing. Applications to the Medical Superintendent.

Appointments.

DIXON, R. G., M.B., Ch.B.Leeds, House Surgeon at the General Infirmary, Leeds.

FLINT, E. R., M.B., Ch.B.Vict., House Surgeon at the General Infirmary, Leeds.

GOULDEN, CHARLES, M.B., M.C., F.R.C.S., Senior House Surgeon at the Royal London Ophthalmic (Moorfields Eye) Hospital.

HUDSON, A. C., M.D., B.C., F.R.C.S., Second House Surgeon at the Royal London Ophthalmic (Moorfields Eye) Hospital.

LANDMAN, A. J., M.B., Ch.B.Leeds, House Physician at the General Infirmary, Leeds.

MACVEAN, H. J., M.B., Ch.B.Vict., House Surgeon at the Bradford Royal Infirmary.

SCARBOROUGH, O. L., M.R.C.S., L.R.C.P.Lond., Resident Obstetric Officer at the General Infirmary, Leeds.

THOMAS, JOSIAH TELFER, L.R.C.P.Lond., M.R.C.S., Surgeon to the Camborne (Cornwall) Public Dispensary.

TURNER, GEORGE GREY, M.B., M.S Durh., F.R.C.S.Eng., Honorary Assistant Surgeon to the Royal Victoria Infirmary, Newcastle-upon-Tyne.

VEALE, R. A., M.B., B.S.Lond., Resident Ophthalmic Officer at the General Infirmary, Leeds.

Births.

COLBY.—On Nov. 9th, at Hill View, Woking, the wife of Francis E. A. Colby, M.B.Camb., F.R.C.S.Eng., of a son.

TOWNSEND.—On Nov. 11th, at 184 Hammersmith Road, Hammersmith, the wife of Meredith Milton Townsend, L.R.C.S., L.R.C.P. Edin., of a son.

Marriages.

COOPER—FOSTER.—On Nov. 10th, at St. James's Church, Hampton Hill, Middlesex, Philip Ward, fifth son of the late Horace Cooper, M.R.C.S., J.P., of Marlborough, to Katharine, youngest daughter of C. R. Foster, of "Armaside," Hampton Hill.

HAINES—STAGG.—On Nov. 10th, at St. Gabriel's, Willesden Green, Charles Frederick Haines, L.D.S., R.C.S Eng., of Worthing, younger son of the late Edward S. Haines, of Stourbridge, and Mrs. Haines, to Vivien Dorothy Cowley, youngest daughter of the late William Stagg, of Cumberland.

ROBERTS—BROWSE.—On Nov. 6th, at St. Luke's Church, Richmond, Edward Hugh Roberts, M.R.C.S., L.R.C.P.Lond., D.P.H.Cantab., of Battersea Park, London, to Violet, second daughter of the late George Henry Browse, of Paignton, Devon.

TIMMINS—SEARLE.—On Nov. 6th, at St. Mary-the-Less, Cambridge, John Lewes Timmins, M.A., M.D., eldest son of John Aaron James Timmins, M.D., late of Mount Hill, Carmarthen, to Ermengard Philippa, younger daughter of the Rev. William George Searle, M.A. (late Fellow of Queen's College, Cambridge), of 11 Scroope Terrace, Cambridge.

Deaths.

HICKS.—On Nov. 8th, at Guildford, Sophia, daughter of the late Robert Hicks, F.R.C.S.

NORTON.—On Nov. 11th, at 23 Grove Road, Brixton, Selby Norton, M.D., aged 70 years.

ROCH.—On Nov. 9th, at Woodbine Hill, Youghal, Ireland, Dep. Surg.-Genl. Sampson Roch, late 55th Regt. and Army Medical Staff, aged 77 years.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

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NOTES AND COMMENTS.

The Jungle chez nous.

EVER since the Chicago sensations shook the foundations of belief in preserved food, we have contended that it is the merest hypocrisy for Englishmen to cast stones at the Americans in the matters of the inspection of food supplies and the conditions under which food is prepared. In a book published last week under the sensational title of "The Soul Market," the authoress, Miss Olive Malvery, has a vigorous fling at several provision concerns in this country. We are not prepared to support or to deny her assertions as regards the particular ones attacked, but we may say in general terms that the "revelations" as to the conditions under which the hands work, the general want of ordinary cleanliness, the putrid state of meat used for preserving, and the decayed condition of fruit used for jam, are exactly what may be expected in a country that regards the production of food as a matter beneath its notice.

A few Details.

MISS MALVERY tells, for instance, of a London meat-packing factory in which tongues and pork, used for pressing and making brawn, were so putrid that they fell to pieces, the smell they emitted being shocking. In times of pressure, she says, the staff was replenished by relays of tramps from the gutter and riverside, whose bodily condition was offensive beyond description. As the entire staff of meat-inspectors of the Port of London, into which some half a million tons of meat are annually imported, is but eight, what can be expected? The facts related in "The Soul Market" call for a rigorous inquiry.

Coventry Dispute.

THERE is apparently a tough fight proceeding at Coventry between the practitioners of the neighbourhood and the Provident Dispensary. The latter possesses no less than 18,000 members, and is therefore in a strong position to make terms. The medical men object, naturally and rightly, to the Dispensary embracing in its membership well-to-do people who are capable of paying ordinary fees, whilst the Dispensary point to the Friendly Societies, which have similar terms for contract practice and number many affluent persons among their adherents. The last move of the Dispensary partisans is a mean one. Dr. Snell, the Medical Officer of Health, is acting as secretary to the local branch of the British Medical Association, and in that capacity is making things "go." Now an attempt is being made to get the City Council to prohibit his holding this purely honorary position, and thus to deprive the movement of much of its influence. We wish all success to the medical practitioners, and trust that the methods of the Dispensary partisans will not be allowed to prevail with the Council.

Vaccination Anomalies.

LAW and logic do not kiss each other in the Vaccination Act, 1898, and the situations that are continually arising in consequence are often grotesque in the extreme. Last week a complaint to the Home Secretary was made by Mr. Lupton, who owes his position in Parliament largely to his anti-vaccination prejudices, that a man mamed Walden had twice been refused an exemption certificate by the Greenwich magistrates, and is now being prosecuted for not having his child vaccinated. The Home Secretary replied that he had no authority in the matter, and that the statute places discretion as to exemption entirely in the magistrates' hands. That is true, and so we see the curious anomaly of a man being disallowed exemption by the magistrates, and prosecuted by the vaccination officer for non-compliance. It cannot be contended that these paradoxical situations bring much credit either upon the law or the practice of vaccination.

Working-Class support for Hospitals.

A JUST criticism with regard to hospital management is that it does not seek to ally itself with the class for which it caters, and consequently the working classes in London and many other places feel and show no interest in hospitals till they are taken ill. In some large provincial towns the active co-operation of the working classes is sought for by the governors and easily obtained, and such hospitals are seldom or never in debt. A striking illustration of the amount of interest taken by the workers of London in the hospitals was reported last week. At Acton, the governing body of the local hospital sent round eighty collecting boxes to large works in their district so that the employés could contribute their mites, undeterred by fear of ostentation. The mites, however, were not forthcoming, for when a collector went round, not one of the eighty contained a coin!

LEADING ARTICLES.

SOME ASPECTS OF MODERN EDUCATION.

MANY of our readers will probably agree with Mr. Birrell's views of education, as expressed at the meeting in the Town Hall, Leeds, on Saturday, November 4th. One important point, however, seems to have received little or no attention. In the terse definition of education—"Doctrina vim promovet insitam"—we have the great principle stated on which education is founded, and by which it should be influenced and regulated. We naturally ask, What is meant by "vim insitam"? What promotes or develops the inherent qualities—that is education? But it follows that before we decide how to educate we must study carefully and know well what are the inherent qualities we have to deal with. By way of comparison, from which much may be learnt, we see what is done in the training of dogs. To try and make a rat-catcher of a Sussex spaniel, or a sheep-dog of a Scotch terrier, would be regarded as rather silly, and we know that we look to the breed of a dog when we begin to train it. Mr. Birrell says that "it would tax more powerful intellects than his to determine where elementary education ended and secondary education began." Human beings, like dogs, differ greatly in their inherent qualities, and it is on the analysis of these qualities that education depends. It looks as if these—that is the "vim insitam"—are really directly due, in their variations, to the simple facts of how the senses of sight, hearing, smell, taste, and voice are developed. In human beings, as in dogs, we see strange variations in the state of the senses; but we have something more to consider when dealing with our own species, namely, the singular qualities that are purely, as far as we can tell, possessed by the brain independently, as it seems, of any of the senses. The power of memory, of calculation, of invention, may depend on some one sense, but we cannot satisfy ourselves that the superiority in some great quality of one man over others can be proved to be due to the unusual development in his case of one of the senses. How is it that one boy may be a good classic, and another a good mathematician? How the brains differ in these cases is strange, and we are disappointed if we try to train the two in exactly the same way. In this country we have left education to those who have been interested in the training, not of the senses, but of the mental powers or qualities of the young. Those who are engaged in the study of law, in the teaching of religion, or in such work as that in which Mr. Birrell excels, are not capable of dealing with the question of education when it is really one of a physiological and physical character. Indeed, none are capable of dealing with the points who have no knowledge of those sciences that are the special study of the medical profession, or of some branch of natural science. Law and theology are naturally more disposed to cultivate languages and literature and moral philosophy and religion than the common nature of human beings—the "vim insitam," the animal qualities we inherit, or are endowed with. "Education began the moment we were born, and ends with the grave. It did not therefore do to exaggerate the more scholastic side of it." We cannot but admire the mode in which Mr. Birrell is dealing with the question of education, and it would be well for those who are following the profession of medicine not to stand aside in a spirit of indifference when they can help so much in the support of Mr. Birrell, when he says "that nothing could ever rob him of the conviction that the education of our race was our gravest problem."

A STATE MEDICAL SERVICE FOR IRELAND.

As will be seen from the report which we publish in another column of the proceedings at the recent Special General Meeting of the Irish Medical Association, the latter body decided by an almost unanimous vote to approve of the principle of the conversion of the present Poor-law Medical Service into a State Service. We can most heartily congratulate the Association on their decision on this, one of the most critical matters which has come before them for some time past. It is no exaggeration to say that not alone was the future welfare of the Association bound up irrevocably with the decision, but also the future welfare of the entire Poor-law Medical Service of Ireland. In particular we desire to congratulate the President, Mr. McArdle, on his wise and statesmanlike change of attitude towards the scheme. As we have said, the opposition of the Association would have been a most serious matter, and it is almost equally necessary that no opposition should be offered by its President. Consequently, we are very pleased to learn that he gave the scheme a whole-hearted support. At its meeting on Friday, the Royal College of Physicians also approved the scheme, and we have little doubt that the Royal College of Surgeons will do likewise. Approvals of this kind are very necessary preliminaries, but, if they are to bear fruit, something more is necessary; and, if the Poor-law Service is to be really altered, medical men must take their coats off in earnest, and work steadily to compel the Government to give effect to the Report of the Commission. It is always difficult to obtain the necessary money for reforms, and the present case will be no exception. The scheme starts with the great advantage of being recommended unanimously by a Commission. In addition, it is known that it will benefit all those with whom it is concerned from the "ultimate peasant" to the members of the Service. Consequently, there is every hope of its accomplishment if it is only kept prominently before the public. In this connection, we regret to see that the general press are not giving the matter the amount

of publicity which its importance warrants. We trust that this is due to accident rather than to design, and that it will be speedily remedied.

NOTES ON CURRENT TOPICS.

"Normyl" Treatment for Alcoholism.

The "Normyl" treatment for alcoholism has several times been the subject of comment in the MEDICAL PRESS AND CIRCULAR, and we have also had the honour of being replied to by the Rev. Hugh Chapman, secretary of the Association for its employment. Our readers therefore scarcely require to be reminded that this "treatment" is a secret one run for the profit of a private individual with no medical qualification, who has induced certain philanthropically-disposed persons to lend their names to the association. Mr. Chapman neglects no opportunity of advertising the treatment, in spite of medical advice to the effect that all these drink "cures" come and go like stars in their courses and that there is nothing in them that is not known to every intelligent medical man. He has now carried the matter into a new phase, for the *Daily Mirror* is selecting five men and five women to undergo the treatment under its supervision, the results of course to be announced in its columns from time to time. Now, is the *Daily Mirror* in earnest? If so, it will appoint an entirely independent committee first to decide whether the victims are what are truly and properly called drunkards, for it is perfectly useless to accept mere *ex parte* statements, or the patients' own word. Then it will publish nothing about the "treatment" for two years or more after the process has terminated, and when it does do so it will make very careful examination as to relapse. Medical men know well that there are no liars like alcoholics, and that their friends will say anything to screen them.

Infant Mortality in Dublin.

THE Coroner of Dublin, Dr. Louis Byrne, has done a public service in once again drawing attention to the high rate of infant mortality in Dublin. It is difficult to obtain any accurate comparison between the rate in the city of Dublin and those in other large towns, since the rates are calculated on the Dublin Registration Area, a district including not only the suburbs but a considerable stretch of country. In the week ending the 3rd inst., however, of 155 deaths registered as occurring in the city, 29 were of children under one year of age, and 28 more of children under five. It would appear, therefore, that more than one fourth of all the deaths are of young children. When it is remembered that but few Dublin mothers are employed in industrial occupation, and consequently that there is but little artificial feeding of infants, it is obvious that the rate is excessive. The fact is that no serious attempt has ever been made to instruct mothers in Dublin in the proper care of their children, and in the proper methods of feeding, where natural feeding has to be abandoned. There is, further, no guarantee that pure milk can be obtained, and it is no uncommon thing to see milk, filthy in appearance and offensive in smell, exposed for sale. Overlaying is a cause of many deaths. Before dealing with this the housing problem must be settled, but, in the meantime, the poor could be taught to use cradles of some sort—old boxes are excellent—instead of taking their children into their own beds. The truth is, however, that in Dublin as in Belfast, the work of the public health authorities is in a scandalously backward state, and the whole system needs revolution.

"When Doctors Disagree."

The recurrent scandal of opposing "expert" medical evidence constitutes a standing reproach to a scientific profession. A thing cannot be and not be, although that is what one gathers from the evidence of five medical men in a compensation action brought against a Hanley colliery company last week. The plaintiff had been knocked off a trolley and sustained injuries which two of the medical men described as fracture of the sternum and of five ribs on the left side, complete dulness in the axillary region, dulness generally, and other signs of serious injury to the lung. The man spat blood for some considerable time after the accident. On the other side two medical men asserted that the lungs were healthy, but the judge clearly did not accept that view, as he allowed the plaintiff 12s. 2d. a week for six months, subject to revision at the end of that time. This case is emphatically one in which two or three experienced medical men could have arrived at an absolute agreement in consultation. Some day it may dawn upon the legislature that the administration of cases involving medical opinion would be placed on a surer, speedier and sounder economical basis were they to be referred to an independent medical board for examination and report. The present system lends itself to obvious abuses and miscarriages of justice, especially in the case of poor suitors, who cannot pay high fees for expert evidence.

A Case for Enquiry at Clacton.

THE week before last a retired medical man was heavily fined for damaging chairs belonging to the District Council, and sent to prison without the option of a fine for wilfully obstructing a cyclist. The extraordinary circumstances of the case suggest that it would be advisable an immediate enquiry should be made into the mental condition of the gentleman in question. His extreme eccentricity has long been in evidence, and, if we remember aright, has been actually commented upon in our own columns. Amongst other things, he has been before the magistrates on a previous occasion for firing a loaded revolver in the street on a dark night. In the present instance he mounted a heap of chairs and threw some of them over the cliff, and the second charge was due to his putting out

his foot and upsetting a cyclist who was passing on the road. We submit with confidence to the authorities that the facts as stated are more than sufficient on the face of them to warrant an immediate informal *de lunatico inquirendo*. The state of the British law as regards police-court and criminal insanity generally is lamentable and wholly unworthy of a scientific age. Lawyers, who make and administer the law, as a class obstinately refuse to recognise the irresponsibility of moral insanity, unless the accused be a drivelling idiot or a wild maniac. But we are glad to remember that the Home Secretary, who has the revision of sentences in his hands, is a common-sense citizen and not a lawyer.

Army Nurses and Dancing.

THE answer recently given by Mr. Haldane in reply to a question why dancing should be forbidden to nurses in the Army Nursing Service, does not perhaps reach the high level of sanity that one associates with the Secretary for War. Mr. Haldane admitted that he himself saw no reason why the nurses should be forbidden to go to dances, but that the experienced matrons and highly trained ladies on the Nursing Board had prevailed over him. Now the Nursing Board is an estimable institution, and no doubt these experienced matrons being long past the dancing age look upon that innocent pastime with the eye of the fox for the sour grapes. But if nurses are to remain human, and not to develope into a caste, it is eminently necessary that they should continue to be of the world as well as in it. It is a stupid piece of prejudice that forbids them dancing, and the sooner it is removed the better.

A Pure Milk Supply.

A pamphlet has just been issued by the Royal Institute of Public Health embodying the report of a committee which they appointed some time ago to enquire into the question of the purity of the milk supply. The committee was composed of medical officers of health, bacteriologists, and representatives of the milk trade. They recommend that the Dairies, Cowsheds, etc. Order of 1885 should be enlarged and strengthened. The order is not nearly so strict as most in operation in the Colonies. It was found that enforcement of existing orders varies in stringency in different parts of the country, and in a large majority of rural districts the orders are completely ignored. The committee urge that the enforcement of the orders should be compulsory upon the local sanitary authority, and in default the authority should be made amenable to the County Council. Perhaps when the legislature has finished fighting over the religious aspect of the educational problem, and has settled all the other questions of high politics likely to absorb its energies for the next few sessions of Parliament, it may be able to turn aside to the small details of the social problem, to devise laws which may tend to prevent the deterioration of the populace upon whose physical vigour the stability of the nation and the empire so largely depend. It has been stated over and over again by the highest authority that if existing sanitary legislation were uniformly carried out with intelligence and zeal throughout the kingdom the annual mortality might be speedily reduced by one-half. The mortality is only a measure of the injury to the physical development of the people by which it is accompanied; and in the matter of milk supply, for example, it is probable that for every infant dead a score survive as ricketty cripples owing to lack of a proper supply of the only food they are capable of digesting and assimilating.

Medical Motorists.

It would be useless to suppose that the proposed tax on automobiles is likely to be popular —that is to say, so far as the mere pleasure-hunting motor is concerned. Obviously it would be an unsound economic proceeding to tax industry by placing an impost upon automobile vehicles used for trade purposes. The question is where to draw the line, a difficulty that is always present in an attempt to establish differential taxation. At a conference of automobilists held in London last week a resolution was carried by a small majority to uphold the favourable treatment of medical men in regard to the taxes on motor vehicles. There is a good deal to be said on behalf of such a proposition, inasmuch as the medical profession forms an indispensable pillar in the social edifice. A vehicle of some kind is absolutely necessary to the general practitioner, especially in country districts, for the proper conduct of his practice. It is not so many years ago that the national voice was raised in condemnation of a proposed tax upon wheels, and it is not altogether easy to realise how there can be any exceptions to the general rule that such taxation curtails industry. In any case it is to be hoped that the short-sighted policy of taxing the locomotion of medical men will not be adopted by the Government.

The Learned Laity.

A LABOURER who came lately to a large London dispensary described himself to the doctor as suffering from "brain-fag," his diagnosis being doubtless gleaned from the symptoms given under that heading in some of the dailies, and an office-boy who came with an hypertrophied liver, gave the doctor the gratuitous information that he had "inflamed membranes," because his "sister, who went to the Physiology Class," said so, and she knew "all about your inside." It is doubtful whether the writing of many books by doctors in a style which might be understood by the intelligent laity, but which are likewise read by the empty-minded, is a very wise procedure, and still more harm is done by medical faddists who use such titles as "menticulture," "humaniculture," etc., and almost imply that disease when it comes is curable by home treatment. A melancholy instance of the right book in the wrong hands is that of "Andrew's Domestic Medicine," with the pages marked at the effects of poisons being found in the room of a young suicide.

The Health of Dublin

The focussing of public attention on the scandalous neglect of sanitary matters in Belfast has allowed the state of health in Dublin to pass almost without notice. Nevertheless, it is not to be forgotten that, high as is the death-rate in Belfast, it is much higher in Dublin. During the September quarter of the present year the respective rates for the two county boroughs were 18·8 and 24·1. Since September, however, the rate in both cities has gone up, and, according to the latest returns, Dublin shows not merely the highest death-rate in Ireland, but the highest in Europe. To find a parallel to Dublin in its mortality it is necessary to travel to India, where Bombay and Madras take the lead. Even Calcutta, where there has been much discussion lately as to the necessity for improved sanitation, shows a lower death-rate. The people of Dublin, however, do not seem in the least alarmed about the matter. A few voluntary societies, such as the Dublin Sanitary Association and the National Association for the Prevention of Tuberculosis, do their best to educate public opinion, but of united effort by the responsible authorities there is little. Dublin is riddled by tuberculosis, and is periodically attacked by typhoid. Typhus is seldom absent for any length of time; diarrhœal diseases more than decimate the infant population. The water supply is not above suspicion, and the milk supply is far from properly controlled. It is not clear, of course, how far a death-rate accurately represents morbidity, but in a city with such an extravagant death-rate the people have a right to expect more than ordinary precautions for the prevention of disease. Their responsibility in this matter has not yet been brought home to the proper authorities.

The Prevention of Lunacy.

The question of the possibility of the limitation of lunacy by legislation is at least as old as Plato, and in recent years it has been revived with a fresh interest. A paper contributed by Dr. Nolan, of Downpatrick, to the October number of the *Journal of Mental Science* is, unlike much writing on the subject, a sober and reasoned discussion. Recognising that State interference in other matters relating to public health has been more than justified, he asks why the function of the State in regard to mental health has up to the present been limited to the protection of the unfit. The question is difficult to answer beyond stating that most of the proposals put forward have been unpalatable in themselves, and have not been backed with sufficient authority to force them on an unwilling public. It remains to be seen whether Dr. Nolan's own suggestions will meet with a better fate. Some of them are undoubtedly sound, such as those for the establishment of a Ministry of Health and of a State Laboratory for Investigation of Mental Pathology. It is more than doubtful, on the other hand, whether early and consanguineous marriages, if otherwise healthy, have any effect in producing mental instability. Most of Dr. Nolan's suggestions, however, are thoroughly feasible, and the wider the audience reached by his paper the better.

PERSONAL.

Princess Louise, Duchess of Argyll, opened the new wing of the Central London Throat and Ear Hospital, Gray's Inn Road, on Monday last, when purses were presented in aid of the building fund.

Mr. Thomas J. Stafford, Medical Commissioner on the Local Government Board of Ireland, has received the Order of Companion of the Bath on the occasion of the recent Birthday Honours.

The Lord Lieutenant has appointed Mr. John Fagan, F.R.C.S.Irel., to be a member of the General Prisons Board for Ireland in room of Dr. Stewart Woodhouse, resigned.

Dame Marian Saunders, of Wimbledon Common, widow of the late Sir Edwin Saunders, for many years surgeon dentist to Queen Victoria, has left £1,000 to St. Thomas's Hospital, for the endowment of a bed in memory of her husband, and £100 each to the following institutions: The Westminster Home for Nurses, the Chelsea Hospital for Women, the Benevolent College, Epsom, and others.

The annual meeting and dinner of the Glasgow University Club for Manchester and District will be held at the Mosley Hotel, Manchester, on November 27th. Further particulars can be obtained from the secretary, Dr. D. Richmond, 176, Drake Street, Rochdale.

Sir T. Halliday Croom, M.D., will preside at the next annual dinner of the Edinburgh University Club of London, which takes place on Friday, November 23rd, at the Criterion Restaurant, Piccadilly Circus, at 7.30 o'clock.

A special meeting of the Medical Society of London will be held on Monday, December 3rd, at 9.15 p.m., when Dr. Henri Hartmann, Professor of the Medical Faculty of the University of Paris, will deliver an address entitled "The Surgical Forms of Ileo-cæcal Tuberculosis."

Dr. P. Watson Williams has been unanimously elected Physician in Charge of the new throat and nose department of the Bristol Royal Infirmary. Dr. Williams has been connected with the Institution for the last eighteen years.

The Council of King's College, London, have appointed Dr. Arthur Whitfield, F.R.C.P., Lond., to the Professorship of Dermatology.

We regret to record the death of Dr. Gustave Isidore Schorstein, of the London and Brompton Consumption Hospitals. Dr. Schorstein passed away on November 16th.

The Treasurer of the Royal Ear Hospital, Dean Street, Soho, has received from the Duchess of Somerset £160, the proceeds of a concert given by her Grace at 35, Grosvenor Square, on the 6th inst., in aid of the funds of the hospital

Dr. J. Lindsay Steven, Member of the General Medical Council, Physician to the Glasgow Royal Infirmary, has been appointed by the managers of the Western Infirmary, Glasgow, to succeed the late Dr. Finlayson as visiting physician.

A CLINICAL LECTURE
ON
THE MEDICINAL AND DIETETIC TREATMENT OF CATARRHS OF THE BLADDER AND PELVIS OF THE KIDNEY.

By G. EDELSSEN, M.D.,
Professor of Surgery at the University of Hamburg.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

THE communications regarding the treatment of catarrh of the bladder during the past ten years are almost exclusively concerned with the newer chemical remedies, whilst the older tried ones are rarely mentioned. At most uvæ ursi and copaiba balsam are considered; Posner points out oil of turpentine, and Quincke chlorate of potash. This one-sided consideration of the newly introduced remedies on the part of reporters—which, however, have in many cases proved their value—might lead physicians to the belief that where the modern remedies fail no more need be expected from internal treatment. But in such a tormenting disease as chronic vesical catarrh it is greatly to be lamented, and the reverse of agreeable to the attending physician, when hopes of internal treatment are not realised, and it is a misfortune to the patient when local treatment of the bladder is had recourse to, which the frequent accompanying pyelitis often makes it impossible to influence, before an attempt has been made to make trial of the internal remedies at our command to bring about the cure of the disease. No one will deny that all washings out of the bladder, whatever the drug employed may be, with its incalculable dangers, is most burdensome for young girls, and with men with strictures of the urethra almost impossible to carry out without an operation. Certainly there is an unavoidable necessity for local treatment of the diseased mucous surface of the bladder under certain conditions, but this method should only be looked upon as a last resort, to be made use of only when all attempts to act on the disease by internal remedies have failed.

The question, therefore, comes up whether the older remedies can be dispensed with since the introduction of the newer, whether in many cases they should not have the preference over these, and whether they must give place to them only in certain well-characterised cases. The newer remedies—urotropine, new urotropine, helmitol, hetraline, and the combined urotropine and fol. uvæ ursi uropural tablets—owe their activity, as is known, chiefly to the splitting off of formaldehyde within the body, which, excreted through the kidneys, acts as a urinary antiseptic, and in favourable cases, by killing the micro-organisms that set up and maintain the pyelocystitis, bring back the mucous surface of the bladder and renal pelvis to a normal condition. These remedies, therefore, are indicated wherever the disease of the urinary passages is caused by pathogenic micro-organisms, such as bacterium coli, typhoid bacilli, and staphylococci, or where the urine has been rendered ammoniacal by decomposition of the urine by other organisms. In these cases, therefore, they must be had recourse to at once, and before trying other remedies.

To-day it is almost an article of faith that every pyelocystitis is of bacterial origin, and the fact that we formerly obtained the best results with the older remedies does not contradict this. These remedies may also have had an antibacterial action, as is certainly true of the balsams and ætherial oils and the arbutine contained in the folia uvæ ursi, as well as of salicylic acid and salol. Chlorate of potash, indeed, has not this action, but it is possible that the excreted salt comes into contact in the urine with pus cells and gives off oxygen, and this in *statu nascendi*, or that one of the chlorine combinations poor in oxygen has a bactericide action.

With the older remedies, with the exception perhaps of salicylic acid and salol, the anticatarrhal vaso-constringing and secretion-checking action was the chief one; in the case of chlorate of potash the action was a directly healing one, and one that furthered the development of new epithelium. Whether, and in what degree, such an influence may be attributable to formaldehyde is at least doubtful. Certainly complete recovery is often brought about by urotropine and its substitutes; but the cases are not rare in which the ammoniacal fermentation is completely arrested, but in which the secretion of pus suffers no diminution on continuance of the treatment; where, indeed, even from the commencement no diminution of clouding or quantity of purulent sediment can be noticed. In gonorrhœal or tuberculous cystitis the powerlessness of the remedy cannot surprise, but one cannot from this negative result in non-gonorrhœal cases conclude that the disease is tuberculous. There may be other catarrhs of the bladder and renal pelvis that have been originally caused by micro-organisms that are capable of running an independent course of themselves, even after the originators of the affection have been rendered harmless, *and the longer the disease has lasted and the deeper the changes that have been set up by it, the less may be hoped that it will be cured by antiseptic treatment alone.* In these cases it is imperative to pass on to the use of the old, tried anticatarrhal remedies. But wherever also there is free secretion of pus, but no ammoniacal condition of the urine, and where col. bacilli or staphylococci are not present, there is every reason to bring into use the old vaso-contractile and secretion-checking remedies at once by which formerly such excellent effects were obtained. Where there is no pronounced bacteriuria nor excessive ammoniacal decomposition of the urine we shall do very well with the old remedies, and obtain by these means what is required to restore a normal epithelium and a normal condition of the urine, even better than with the modern ones.

Amongst these old remedies I place oil of turpentine, copaiba balsam, chlorate of potash, folia uvæ ursi, salicylic acid, and salol. In tuberculous pyelocystitis one will do best from the employment of creosote and guaiacol; in gonorrhœal cystitis with copaiba balsam, which is to be preferred even to gonosan. I have no experience of arhovine and santyl. The most powerful remedies in non-gonorrhœal cystitis are oil of turpentine and chlorate of potash. It is, indeed, less the doubt as to their efficacy that has made physicians turn from them to the newer remedies than the fear of the

injuries that may be caused by them. The use of oil of turpentine may occasionally be followed by strangury and even slight hæmaturia. But if the drug is stopped in time one need never fear any permanent injury. Even in acute catarrh of the bladder it does excellent service, and often brings about recovery in a few days, just in the same way as is often observed in gonorrhœal cystitis after treatment with copaiba balsam. Want of appetite is not a contra-indication against the use of the drug, for that is generally only a consequence of the main illness itself. It is often enough observed that in such cases the use of oil of turpentine or of copaiba balsam along with the favourable influence on the bladder improves the appetite also. It is only in grave gastric disorder that the remedy is contra-indicated.

A weighty objection to chlorate of potash is the poisonousness of large doses when given internally. This view widely spread has led to its avoidance in catarrh of the bladder, or to its being prescribed in doses so small that they can do no good. There is no reason for this excess of caution, however. Except in two cases recorded by Quincke, in which poisoning took place when the remedy was given for vesical catarrh in doses efficient for the purpose—*i.e.*, 0.5 to 0.75 grm. six to eight times daily, in adults—all the other known cases of poisoning by chlorate of potash were by the administration of a single large dose, unsuited to the age of the patient, or to smaller doses too rapidly pushed one after the other. Even when the small doses necessary in vesical catarrh are given, even when there are no symptoms of poisoning, and especially of methæmoglobinuria, a small number of the red blood corpuscles may be destroyed, but this slight loss of eventual erythrocytes must always be very quickly made good. For even when the drug has been given for months together I have never observed any loss of colour in the face or other sign of commencing anæmia; on the contrary, the patient's looks improved with the progressive improvement in the catarrh of the bladder. Independent, therefore, of some cases in which chlorate of potash is absolutely contra-indicated, there is no reason to avoid the use of chlorate of potash in the treatment of either acute or chronic catarrhal inflammation of the bladder.

But, indeed—this must be again emphasised—of a remedy the action of which depends on its being excreted through the kidneys chiefly in an unchanged condition, and on the degree to which it can be estimated in the urine, something can be promised only when it is given in a dose that allows the freest excretion possible in the urine. In my experience, in the case of adults, 0.75 six times a day answers well (15 ccm. of a solution of 15 grm. in 300 ccm. of water), equal to 4.5 grammes a day in six equal doses; but in unusually bad cases, when the patient is strong, the like dose may be given without any misgiving eight times a day—that is, 6 grammes per diem. That the dose must be modified in children, according to their age and constitution, goes without saying. The contra-indications against the use of chlorate of potash are only acute nephritis, general cyanosis the result of emphysema and cardiac insufficiency, or of congenital or other non-compensated acquired valvular disease of the heart, and also icterus.

As may be supposed, neither of the medicines will work equally well in every case. It may happen that where one has completely failed, the other has the best results. It cannot be determined beforehand in any particular case which of the two promises best. One must be given, and if it does not prove sufficiently useful the other must be put in its place. In very rooted cases a repeated change of the two remedies may be useful, and with a good function and tolerance of the digestive organs both may be given together for a time in the usual doses with perfect safety, and with a good result. In other cases a combination of chlorate of potash with fol. uvæ ursi has been very successful (chlorate of potash 15 grm, decoct. fol. uvæ ursi 3 : 300; one tablespoonful six to eight times a day). Where also there is no proper catarrh, but only an excessive irritability of the bladder (irritable bladder of the English), chlorate of potash may do excellent service.

Without being an opponent of all local treatment of vesical catarrh, I am of opinion that it should be used in those cases only in which internal treatment fails. It should not be undertaken without necessity, and physicians would be much less frequently placed in a position of being obliged to wash out the bladder if they more frequently made use of the old, tried remedies for cystitis. For washing out, the milder remedies will generally be sufficient, and especially the 3 per cent. solution of chlorate of potash recommended by Boegehold; silver nitrate will only be necessary in rare cases. Boric acid and resorcin, both in 2 to 3 per cent. solution, have also proved very useful. Washing out with permanganate of potash is not without danger, as the possibility is not quite excluded that the sediment caused may not in part adhere to the mucous surface of the bladder, and occasionally may give origin to a concrement.

It is not necessary to prescribe a special diet in order to bring about recovery in acute and chronic vesical catarrh. After a daily examination of the urine, I have never observed that the case got worse when any unpermitted articles of food were taken, or that the action of any remedy was in any way impeded. This applies as well to dark meats as to pickled or salted or smoked, and to fish; and as the favourable action of the æthereal oils or the products of their change within the system on the mucous surfaces is generally recognised, there seems to be no reason for prohibiting pepper, mustard, and other spices in moderate quantity, so long as the digestive organs and the kidneys are sound. I have even occasionally permitted asparagus; but perhaps it would be more proper to cross off the diet list for bladder sufferers a food that has no special nutrient value, and one that changes the character of the urine in such a striking manner. By allowing greater freedom in the choice of foods the appetite that frequently sinks under a monotonous diet is rapidly restored, and improved nutrition is of great importance in such a tedious and weakening disease.

The forbidding of the use of alcoholic drinks is well founded. Even slight excesses in this direction have resulted in a marked increase in the vesical catarrh. During the course of treatment of a case of cystitis or pyelocystitis, both acute and chronic, spirituous liquors are to be forbidden to the patient entirely. In chronic catarrh of the bladder, people who have been accustomed to wine, however, may have a little red or Moselle wine mixed with water allowed. Beer certainly does harm, owing to the hop it contains—and especially new beer—and which, according to the researches of Rintaro Mori, if taken in large quantities causes severe irritation of the bladder mucous membrane, even in healthy individuals, and is to be looked upon as the cause of the so-called beer-drinker's clap (Biertrippers).

As regards the allowance of water, the old maxim was fully justified that a free supply of water should be allowed, enough to provide for efficient dilution

of the urine and washing out of the bladder in the natural way. Whether plain water or milk, buttermilk, or diluted tea, or mineral water, is of no consequence, so long as the urine is acid; but when the urinary reaction is alkaline, all alkaline mineral waters are to be avoided, and only plain water or effervescing mineral water, such as Seltzer, Apollinaris, or Hanza Sauerbrunnen or Kaiser Friedrich, Quelle, Oberbrunnen or Gieshubl or Wernarzer Brunnen, should be allowed, and in cases of acute vesical catarrh, even when the urine is acid, are to be preferred to the Wildunger, Fachinger, Vichy, and Biliner waters. With the dilution of the urine, with its diminished irritating action on the mucous surfaces of the bladder and urethra, the frequent desire to micturate ceases, and by-and-bye the cutting pain felt after micturition. In spite of the increased quantity of urine, therefore, the intervals between the different acts of micturition become longer. But it must be borne in mind that the urine must not be so much diluted that the remedy passes through in an insufficiently concentrated form to produce its effects, and so is less active. The mineral waters that very justly have a name as useful in bladder cases, and especially those of the Wildunger Spring, should not be taken to such an extent that they interfere with the action of the medicinal remedies.

NOTE.—*A clinical lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by Professor F. Widal, M.D., Physician to the Paris Hospitals, on "The Dechloridation Treatment in Cardiac and Renal Disease," specially reported for this journal.*

ORIGINAL PAPERS.

A PLEA FOR THE STUDY OF THE INTERMEDIO-LATERAL TRACT OF THE SPINAL CORD. (*a*)

BY ALEX. BRUCE, M.D., F.R.C.P.ED.,
Physician to the Edinburgh Royal Infirmary,
AND
J. H. HARVEY PIRIE, B.Sc., M.B., B.Ch.

IN a *resumé* of the development of our knowledge of the anatomy of the intermedio-lateral tract, Dr. Bruce recalled that it had been described by Lockhart Clarke in 1851 as extending from the lower cervical to the upper lumbar region of the cord. In position it lay in the grey matter intermediate between the anterior and posterior cornua of grey matter. It attracted little or no attention after Clarke's time until Waldeyer described its position in the cord of the gorilla. According to him it extended into both the cervical and lumbar regions, but Dr. Bruce's observations showed that in man the tract began in the middle of the eighth cervical segment, and extended down to the middle of the second lumbar segment. It was an important tract as regards the number of its cells, which differed in appearance from those of the grey matter of the cervical and lumbar enlargements. The cells were arranged in two groups, one behind the other; to the former the speaker provisionally gave the name "lateral," to the latter, which overlay the formatio reticularis, he applied the name "reticular." The next matter raised was the question as to whether the cells of the intermedio-lateral tract were the spinal centre for the efferent fibres of the sympathetic system. Gaskell had discovered that the sympathetic fibres were of two kinds—medullated and non-medullated—the former being the efferent fibres. Drs. Bruce and Pirie had counted the cells in the intermedio-lateral tract in serial sections of the cord, and showed their distribution graphically on a chart. On comparing this chart with a scheme of the sympathetic system, it was found that in those segments from which the largest numbers of efferent sympathetic fibres sprang there were the largest numbers of cells in the tract in question. The coincidence was so striking that it was difficult to avoid the conclusion that the tract and the sympathetic system were related, and that the former was the spinal origin of the efferent fibres of the latter. The examination of this region of the cord, therefore, in cases in which there was affection of the sympathetic system, might be expected to yield results of interest, and in illustration of this specimens were shown taken from a patient who had died from acute anterior poliomyelitis. There was absolute flaccid paralysis of the lower limbs with abolition of the reflexes and some implication of the bladder and rectum. Towards the end of his illness the patient suffered from pyrexia from cystitis, with profuse sweats. It was then observed that however copiously the perspiration flowed from the face, arms, and upper part of the body, the skin of the legs remained absolutely dry. Dr. Bruce had therefore hazarded the opinion that there would be found, in this case, lesion of the intermedio-lateral tract as well as of the anterior horns. The specimen shown confirmed this, for the same congested appearance, with degeneration of the cells, was seen in both sites. The question might be raised, why was this not more common in anterior poliomyelitis? The reason was, that the lesion was seldom extensive enough. In this case the inflammatory condition had involved not only the grey matter of the lumbar enlargement, but extended longitudinally into the dorsal region of the cord. He had also examined the intermedio-lateral tract in a case of another disease in which sympathetic symptoms were a prominent feature—namely, exophthalmic goitre. In it, as well as in other regions, he found hæmorrhages, which were probably terminal, and on which he laid no stress. But in the intermedio-lateral tract region there was also hyaline degeneration of the vessels, and degeneration of the nerve cells. Without entering upon the question as to whether these were the primary lesion or not, and whether the disease was or was not a condition of over-action of the thyroid, he suggested that the lesion found constituted the anatomical basis of the sympathetic symptoms of Graves' disease. Many other diseases in which symptoms due to involvement of the sympathetic occurred would suggest themselves, and he had brought forward his paper as a plea for the more thorough examination of the lateral region of the cord.

(*a*) Abstract of Paper read before the Edinburgh Medico-Chirurgical Society, November 7th, 1906.

Dinner of the Medical Graduates College and Polyclinic.

THE eighth annual dinner of the Medical Graduates' College and Polyclinic will be held at the Trocadero Restaurant, Piccadilly, on Wednesday, December 12th, at 7.15 for 7.30 p.m. Dinner tickets, 7s. 6d. exclusive of wine, may be obtained from the Medical Superintendent, 22, Chenies Street, Gower Street, London.

NOTES OF A CASE OF OVARIAN CYSTOMA IN WHICH THYROID TISSUE OCCURRED. (a)

By J. HUTCHINSON SWANTON, M.A., M.D., M.Ch., M.R.C.P., Lond.

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TUMOURS of this description are of such rare occurrence that it seemed opportune to exhibit this specimen, and read some notes of the case.

The patient, E. G., from whom I removed this tumour, was sent to me in January, 1903, complaining of attacks of nausea and vomiting, followed by a bearing-down sensation, which came on after standing every evening. She was 42 years of age, and stated her menstruation began when she was fifteen; the periods came on regularly every twenty-eight days, lasted five days, and used two diapers daily. Slight pain came on one hour before each period, which ceased when the discharge appeared. Married ten years, and had three children, the youngest aged 3½ and eldest 9 years. One miscarriage happened ten months previously, after four months' pregnancy, caused by taking an abortifacient.

Her labours were described as being good, but the perinæum ruptured during the first, and was sutured three days afterwards. Both kidneys were movable, the left lying in the iliac fossa. The cervix was lacerated on the left side, and the uterus was in an early stage of descent. Some thickening of the mesometrium on the left side was found near the upper border. The kidney on the left side was easily pushed back into the hypochrondrium, and after the application of a suitable pad and belt the symptoms complained of disappeared.

The patient was seen by me again on April 24th, 1906, and stated that on April 6th an attack of pricking pain came on during the night in the lower part of abdomen, which was relieved by fomentation. On getting up next day the pain returned and became paroxysmal. Menstruation appeared on April 16th, and lasted seven days. On examination the left iliac and lower hypogastric region were slightly prominent, and respiratory movements diminished. A definite swelling was found occupying these regions, which gave impaired resonance. The vesico-uterine pouch was occupied by a fluctuating swelling, which caused pain on manipulation. The uterus was not enlarged, but displaced to the right. The left fornix and adjacent part of the pouch of Douglas were occupied by a smooth resistant swelling, the size of a fœtal head at seven months, which could not be pushed up out of the pelvis. Several mucous polypi projected from the cervix.

I advised operation, and on May 8th of this year performed cœliotomy through an extramedian incision 6 cm. long to the left of the middle line. On opening the abdomen an irregularly lobulated mass was found wedged in the left side of the true pelvis. Anteriorly it was dark red, but behind was of a pearly colour, with isolated patches of dense structure irregularly distributed. There were no adhesions, and after enlarging the abdominal incision, the tumour was lifted out of the pelvis. The left ovary and mesovarium were taken up by the growth. A gauze packing was placed around the pedicle, and enclosed the tumour. One thin-walled cyst on the anterior surface ruptured during removal, but the contents were absorbed by gauze. The pedicle was ligatured, divided, and peritoneum sutured over the stump. The abdomen was closed by through-and-through sutures of silk orm gut; peritoneum was closed by continuous suture of catgut sterilised after Moschowitz's modification of Claudius's method. The sheath of the rectus was closed by interrupted silk sutures and skin united by catgut. The patient was then placed in the lithotomy position, when the ploypi were removed from cervix and uterus curetted. Two pints of saline solution, at temperature of 99°, were then injected high up into the rectum, before the effect of the anæsthetic passed off.

The temperature on one occasion within twenty-four hours after operation rose to 100° F.; otherwise convalescence was satisfactory, and patient returned home on the twentieth day. On July 25th the patient was examined, when there was only some thickening in the outer portion of left mesosalpinx.

The specimen was examined by Cuthbert Lockyer, who reported that—

In general appearance the tumour is tri-lobed, the lobes consisting of three large cysts, the largest measuring 3 inches in both its diameters; the next in size measures 2½ inches in both its diameters; whilst the third measures 2½ by 2¼ inches. The largest cyst has extremely thin walls, and is therefore quite translucent. By transmitted light yellow tissue is seen to exist in patches on the inner surface of the wall. The fluid from this cyst is of a greenish-yellow colour, and of limpid consistency. The other two cysts have thicker walls, the one intermediate in size is filled with thickish fluid, chocolate in colour, and laden with cholesterin crystals. Adherent to the inner wall of this cyst are irregular flakes of old blood-clot. The third cyst contains a fluid which is deep orange in colour and in which large flakes of lymph float about; on its inner wall are seen patches of bright yellow tissue, and in the substance of its wall the remains of a corpus luteum can be traced. The outer surface of all the cysts is perfectly smooth, showing no signs of adhesion. A few delicate capillaries form a network over the wall of the cysts. At the confluence of these three cysts there exists a solid mass of tissue, which on section presents a multilocular cystic appearance, the loculi being filled with solid colloid material. In addition, projecting from this solid mass there is a thin-walled cyst, circular in shape, with a diameter of 1 inch; the fluid contents of this small cyst are of a deep orange colour, and yellow flakes are seen on its inner wall. Externally, this solid mass presents a few very thin-walled cystic portions, which have been broken during removal. The fluid from the three large cysts becomes solid on boiling only after the addition of acetic acid. The fluid from the small cyst only partially coagulated when treated in the same manner. The pedicle of the tumour has been cut short, so that no mesosalpinx or ovarian ligament are to be seen.

Sections of each cyst-wall and also of the colloid central part of the tumour have been made.

The tissue has a thyroid structure consisting of loculi lined by low-lying cubical epithelium, and containing colloid material in which lie ghost-cells and spaces occupied originally by fat crystals.

The microscopical section shows a smooth outer capsule undergoing hyaline degeneration; inside the ovarian stroma is somewhat broken up with clear spaces between as if œdematous. Numerous groups of deeply stained nuclei are seen irregularly arranged, some of the cysts being more surrounded than others. Then comes a reticulated structure, and beyond this several cysts with low cubical epithelium. The central portion is stained wth eosin, and in some cysts is separated from the wall. In the central portion may be seen empty spaces, some oval, while others are irregular.

The case is more interesting from a pathological rather than clinical standpoint. Nine specimens of this variety of tumour have been described. In 1899 Gotschalk (1) was consulted by a woman, æt. 88, suffering from ascites and marked cachexia. On operating, a solid tumour of one ovary was removed. The patient was discharged.

Numerous small cysts were found in the peripheral part of the ovary lined with cubical epithelium and filled with colloid material. Several hæmorrhagic infarcts were seen between these cysts. It was called Folliculoma malignum, and there is some doubt whether this case ought to be included.

In 1903, R. Meyer (2) removed an ovarian cystoma, associated with a solid tumour of thyroid tissue, from

(a) Paper read before the British Gynæcological Society, November 8th, 1906.

a patient, æt. 55, who had ten children. The same year Adolf Glockner (3) showed a specimen of similar nature removed from a patient, æt. 57. The symptoms were caused by pressure; there was no ascites, and patient left the clinic twenty days after operation. In 1904 Kretschmar (4) described another case, occurring in a patient æt. 48, which affected the left ovary. Polano (5) described two cases, one of malignant nature, where the patient was well two years after operation. In this specimen the growth was characterised by large reticulated spaces presenting a honeycombed appearance, and showed normal thyroid gland, colloid bronchocele and malignant growth.

In 1905 Ulesko Strogonowa (6) showed a specimen before one of the Russian societies.

Eversman (7) described a specimen from Fritsch's clinic.

Last year Hamilton Bell (8) showed two specimens before the Obstetrical Society of London, and during the discussion Targett and Williamson mentioned some specimens they had seen.

The genesis of these growths presents an interesting topic for observation and speculation, and may be classified into physical, metastatic, and embryonal. That the appearance is due to pressure of the surrounding structures or of the contents is founded on the alteration which the thyroid undergoes in Graves' disease, as Edmunds has shown, where the colloid material disappears and cells formerly cubical become columnar, and also when the parenchyma becomes hypertrophied, the cells of the acini become flattened out. This may be an explanation where the acini are numerous, but in many of the sections nothing of the kind is found. The suggestion has been made that these are ordinary cystic adenomata undergoing some peculiar form of colloid degeneration. It is known that the thyroid gland contains thyriodin, which is an iodine combination. Bauman and Ostwald have applied a chemical test to these growths, and have found that 16.215 grams of the growth yield .000225 gram of iodine. This reaction has not been found in any other ovarian tumours.

Another explanation is that these growths are metastatic, having come either from a normal thyroid or one infected with malignant growth.

Some of the cases mentioned have had enlargement of the thyroid, but not all, and in the case I have described there was no enlargement during the period of observation. Normal thyroid gland may grow into blood vessels and give rise to osseous metastasis, as stated by Oderfeld and Steinhaus (9) but there is no evidence to show that this occurs in soft tissues. This opinion is held by Kretschmar, in the paper alluded to previously, although formerly he considered the growth an endothelioma. The most probable explanation is that these growths are embryomata, and more particularly teratomata.

The teaching of Wilms (10) is that a teratoma must consist of the three germinal layers, but subsequent observers, as Nauwerk (11) and Glockner (12), do not consider this essential, as either one layer or some differentiated cells of any layer may be evolved at the expense of the remainder. According to the embryologist Bonnet (13), ovarian embryomata arise from wandering blastomeres which escape from the fecundated vitellus during the process of cleavage, and find their way into the urogenital area. At the onset of puberty these become an elementary structure planed like the normal embryo and consisting of three layers. The normal ovary probably contains an internal secretion, and it is not unreasonable to suppose that in the course of development certain ovular toxines may be produced which act on the cells of the germinal layers in an analogous manner to that of hæmolysins on blood cells. (14)

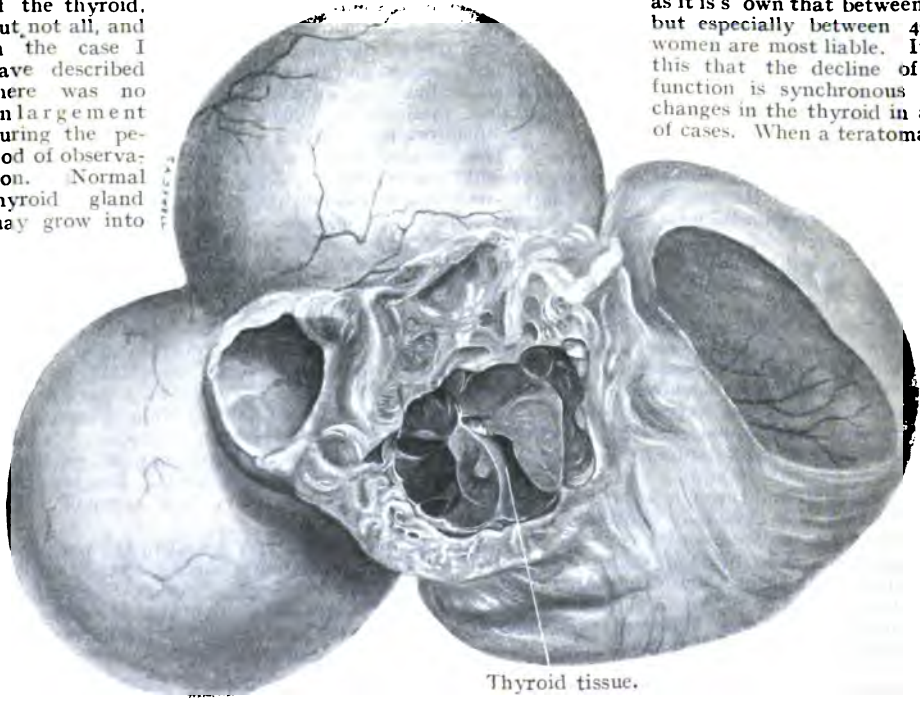
Some evidence may be advanced that a change of such a kind does take place. Saxer of Leipzic, in 1902, made a *post-mortem* examination of a woman, æt. 46, who died from hypostatic pulmonary hyperæmia, and discovered a well-developed single tooth in the right ovary, which was otherwise normal. This tooth was enclosed by a wall of dense ovarian stroma 1 mm. thick, containing numerous lymphatic spaces. This specimen may be seen in the museum at Leipzic. (15)

The presence and persistence of this product of one of the germinal layers may be explained on the hypothesis previously stated.

The persistence of thyroid tissue may be partly attributed to the greater liability of women to perversions of the thyroid gland. Sir Thomas Watson has shown that of 360 cases of thyroid disease, 330 were women. Murray collected a series of 370 cases of myxœdema, and of these 322 were women. Run and Prudden (16) found that of 150 cases 113 were women.

The age incidence of thyroid disease is noteworthy, as it is s own that between 35 and 45 years, but especially between 40 and 45 years, women are most liable. It will appear from this that the decline of the reproductive function is synchronous with pathological changes in the thyroid in a large proportion of cases. When a teratoma of thyroid tissue exists in the ovary at the time of diminishing activity of the thyroid gland, a compensatory hyperplasia may take place, which subsequently develops into either an innocent or malignant growth.

I would therefore submit that the balance of evidence in this case is in favour of this growth being a teratoma.



OVARIAN CYSTOMA WITH THYROID TISSUE.

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MEDICAL TREATMENT OF UTERINE HÆMORRHAGE. (a)

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IT is with some diffidence that I venture to speak on the subject of the Medical Treatment of Uterine Hæmorrhage. The question is so wide that I fear that the time at my disposal would be far too short to enter into the matter at the length which the subject demands. I will, instead, read the notes of the various forms of medical treatment which I have used in those cases of bleeding from the uterus which necessitated medical attention. At the outset I wish it to be distinctly understood that I do not suggest for one moment that the medical treatment of uterine hæmorrhage is to be used to the exclusion of surgical treatment. So far from this being the case, I hope to show later that in several instances medical treatment has been used to improve a condition with a view to operative treatment later on. I do wish, however, to emphasise the fact that there are numerous conditions which yield to medical treatment, if they be but given a chance—cases which are too hastily advised to undergo operative treatment, when, with suitable medical treatment, they can be put right. I need hardly mention that it is useless to attempt the treatment of hæmorrhage, and I think this applies equally whether the treatment be medical or surgical, until the actual cause of the bleeding has been ascertained. It is essential that the diagnosis, as far as possible, should be based upon pathological research, as well as upon clinical grounds; the proper treatment can then be decided upon.

I have in these notes excluded all those cases which were treated surgically, except in a few instances which require mention on account of treatment received before operation was resorted to, or in one or two cases in which medical treatment was adopted when the condition was not relieved by operative treatment, and have related only those which, after a careful diagnosis, I considered suitable for medical treatment; and I may mention that these form the greater number of the cases which have come under my care, and it is this fact which induced me to lay before you the different remedies I have used. I am not suggesting that the means I have employed are original, with the exception of one, which, so far as I know, has never been applied to the treatment of hæmorrhage from the uterus, though it has been used in treating hæmorrhage from the lungs. I refer to the use of gelatin. The cases in which I have used it are only three in number, and, though successful in these cases, I realise that they are not sufficient in number on which to base any conclusions.

In order to save your time, and to avoid the tedium of reading through a list of cases, I have placed in your hands a tabulated list, showing the number, the initials, age, condition, cause, in so far as this could be ascertained, treatment employed, and result. In several of the cases many different remedies were tried, but I have only appended those which were successful in checking the hæmorrhage. For instance, in Case 3, ergot, hydrastin compound, calcium, and finally curettage were all tried. Even after curettage there was profuse menorrhagia during the two subsequent periods. I then tried gelatin, which was successful in reducing the periods. The scrapings from this case showed no signs of malignancy. In Case 24, several remedies were tried before the successful one was found—viz., neutral cotarnine phthalate. In Case 26, gelatin was again used with success, after curettage had failed. Case 67 had been curetted before the patient came under my care. Here cotarnine phthalate, which had been uniformly successful, failed utterly, as it did also in Case 73. Hydrastin compound was successful in both.

Case 41 is interesting in that I believe it to be due to hæmophilia, but there is nothing in the family history to support this diagnosis. There was no pelvic lesion that I could discover, but the patient had had a very severe hæmorrhage after the extraction of a tooth. She once cut herself with a piece of glass—only a slight cut—yet the bleeding was very difficult to control, and she states that she bleeds on the slightest provocation. Her periods have always been profuse; she has had two children; and after each birth she flooded. She was tried with ergot, hydrastin, adrenalin, and finally with calcium This last was successful in reducing the period from ten days to six, with a corresponding reduction in the quantity.

A word as to the drugs used. Ergot I used either as the liquid extract or ergotin hypodermically. The following formula, as suggested by Sir Alexander R. Simpson (1) is the one which I have always employed. I have had it put up in sterilised glass capsules, hypodermates, by Rogers:—

℞ Ergotin	...	...	...	ij. dr.
Aquæ	...	...	...	vj. dr.
Chloral hydratis	...	...	...	dr. ss.

Twelve minims of this equals three grains of ergotin. I always used it in those cases in which I deemed it necessary to obtain uterine contractions, such as subinvolution, in post-partum or post-abortum cases. In the same class of case I have used the hydrastin compound, a combination recommended by Macnaughton Jones (2), containing hydrastin, ergotin, cannabin tannate, and cotarnin hydrochloride (stypticin). This was employed either in the palatinoid form of Oppenheimer, or tabloid of Burroughs and Wellcome.

Cotarnine hydrochloride (stypticin) I have not used alone to any great extent. It has no advantage over the hydrastin compound, but it has the disadvantage of producing headache and giddiness. This sometimes happens with the hydrastin compound when continued for any length of time, and I am inclined to think it is due to the cotarnine hydrochloride contained in it.

Ernutin, which is said to contain only the active principle of ergot, I have used in one or two cases,

(a) Paper read before the British Gynæcological Society, November 8th, 1906.

but as it is not recorded in the present series, I do no more than mention it.

Of calcium I cannot speak too highly. The researches of Sir A. E. Wright (3) on the coagulability of the blood have given us a remedy for uterine hæmorrhage which, in suitable cases, cannot be overestimated. If it does not actually check the hæmorrhage in all cases—and I do not pretend that it does—it at least improves the quality of the blood, and, should an operation become necessary, it will be found that the condition of the blood, and consequently of the patient, is very much improved. Case 30 bore this out in a striking manner. The patient had a large fibroid, with profuse menorrhagia. She was given calcium, which slightly checked the hæmorrhage, but it was remarked at the operation (hysterectomy), which took place three weeks after the first administration of calcium, in what good condition her blood was. Probably most of us have noticed that in these cases the blood has a very watery appearance. It has also been remarked that in operations for gallstones (4) the administration of calcium chloride prior to the operation, especially in those patients who are jaundiced, by increasing the coagulability of the blood, lessens the tendency to bleeding. I regret very much that the coagulability of the blood in the above cases was not determined. I feel convinced that in many of these cases the coagulable point would be found to be much below normal, and particularly in fibroid disease. I hope later to investigate the coagulability of the blood in similar cases.

In a paper by Wright (5) on chilblains, he showed that the coagulability of the blood in this condition was always below normal, and he proved, by the administration of calcium, by bringing the coagulable point up to normal, that the chilblains could be cured. I mention this because, in two cases of menorrhagia, 33 and 57, both were sufferers from chilblains, a fact I was not aware of until both wrote and told me that during the winter they were taking the medicine they had no chilblains, and asked if it were due to the medicine, and, in view of Sir A. E. Wright's statement, I have no doubt that it was. I have used both the chloride and lactate, and find one as good as the other. The lactate is the more pleasant, or, perhaps I should say, the less disagreeable, of the two. I have prescribed them in the following manner:—

℞
Calcium lactatis ... ... xxx. gr.
Aq. Chloroform ad ... ... oz. j.
Sig: To be taken three times daily an hour before food.

℞
Calcium chloridi ... ... xxx. gr
Ext. glycyrrhiz. liq. ... ... xxx. m
Aq. Dest. ad ... ... oz. ss.
Sig: To be taken with an equal part of water three times daily.

The medicine should be taken throughout the period, and I think that it is advisable to take it at least a week before the period is expected.

Neutral cotarnine phthalate is, as far as I know, not very well known in this country, though it has been employed extensively in Germany. Katz (6) states that styptol is the neutral phthalic acid salt of cotarnine. Cotarnine is a base which was prepared some time ago by Wohler by oxidising the opium alkaloid narcotine with manganese dioxide and sulphuric acid according to the formula:

$$C_{22}H_{23}NO_7 + H_2O + O = C_{10}H_{10}O_5 + C_{12}H_{15}NO_4$$
Narcotine Opianic Acid Cotarnine

The hæmostatic action of cotarnine is well known, it having been tested in the above-mentioned drug, stypticin, which is the hydrochloride of cotarnine. The trials rested at first entirely upon the external application of phthalic acid and of acid phthalic acid, but it was found that this acid salt had an irritating action, so that the neutral phthalic acid cotarnine was adopted.

This neutral phthalic acid cotarnine, called styptol, is a yellow, crystalline powder, readily soluble in water, and contains about the same amount of basic cotarnine as does the hydrochloride—viz., 73 per cent. It is given in doses of ¾ grain three or four times daily. I have, however, in some cases given 2 grains four times daily As will be seen on reference to the table, I have used this drug fairly largely, and with very gratifying results, and in only two instances, referred to above, did it fail to check the bleeding. How it acts I am not prepared to say, but inasmuch as it has, in addition to its powers as a styptic, sedative qualities, I think I may safely say that it does not produce uterine contractions. I think it is probable that it acts on the vaso-motor system. This assumption is supported by the following experiments conducted by Möhr (7). A rabbit near the end of gravidity, weight 2,700 grammes, pulse 210, respiration 184 per minute (anæsthetised by urethane). Laparotomy was performed under all precautions, while the animal was in a salt bath. One uterine cornu with a knuckle of intestine were exposed. After half an hour a hypodermic injection of 50 cgms. of styptol was given. Half an hour later weak peristaltic movements appeared in several intestinal loops; the uterus and its appendages, however, remained perfectly quiet, although its ability to contract was proved by direct faradic stimulation of the muscle.

The next experiment was made upon a rooster. It is well known that when roosters are fed upon ergotised corn for some little time, the combs and wattles, which are extremely vascular, become gangrenous. Möhr gave a young healthy rooster 5 cgms. of styptol daily for four weeks, then 7½ cgms. daily for two weeks, and finally 10 cgms. daily for one week. The tips of the comb retained their normal colour throughout, and the bird remained in perfect health.

In two cases of carcinoma, 48 and 64, one inoperable, and one in which operation was refused, besides checking the bleeding, it had quite a marked analgesic effect. This was also noticed in Case 93—membranous dysmenorrhœa. I have not tried the remedy locally, but I have no doubt that, used as a dusting powder in cases of inoperable carcinoma, where there are large, raw, sloughing surfaces, it would promptly check the bleeding and also relieve pain. Indeed, Abel (8), who has used it externally in this manner, says that the powder acts directly upon the exposed open vessels, and considers that this local action is due to the phthalic acid contained in the neutral cotarnine phthalate. In hæmorrhage of the climacteric it is especially useful, and in not one case of this kind in my series did it fail. I have seen no unpleasant after effects such as giddiness, headache, or gastric disturbances.

One case, 90, miscarried, but I do not think that this was due to the action of the drug. The bleeding had ceased some little time, and she had discontinued the drug. The other case of pregnancy continued to term. I have at present another case five months pregnant, who had slight hæmorrhage, who is taking the drug, and at present she is perfectly well. I think in neutral cotarnine phthalate we have a very valuable aid in checking uterine hæmorrhage.

The use of gelatin as a means of treating aortic and other deep-seated aneurysm by causing coagulation of the blood was first suggested by Lancereaux (9). I had long thought it desirable, after reading his paper, to try it in uterine bleeding, but considered the risks of subcutaneous injection too great to warrant my using it in this manner, but a paper by H. M. Tickell (10) on "The Gelatin Treatment of Hæmoptysis," in which he suggested using gelatin by the rectum, quoting successful cases, induced me to try it, for I thought that if it could check bleeding from the lungs when administered in this manner, it should also be able to check bleeding from the uterus.

In the following three cases it did check the hæmorrhage. In Case 3 the patient's period usually lasted 12 days, even after curettage. With gelatin it was reduced to 5 days and a corresponding reduction in quantity.

The gelatin is prepared in the following manner:—50 grammes (about 1¾ ozs.) of the best French gelatin

are dissolved in 1¼ litres (2 pints 3¾ ozs.) of boiling water. This is boiled very gently for one hour, when the volume is reduced by evaporation to 1 litre. The solution is then cooled down to the body temperature, and a quarter of a litre (nearly 9 ozs.) is slowly passed into the rectum by means of an ordinary irrigator. It is preferable to have the solution made up by a reliable chemist, and if the bottles (each bottle containing sufficient for one dose) are sealed with paraffin, there is no likelihood of the solution becoming infected. If this is done the following course should be adopted:—Place the bottle containing the sterilised gelatin in water, and bring the heat up to 100 deg. F. Place the funnel and tubing of irrigator in very hot water for a few minutes. Pass the tube into the rectum, and slowly pour the gelatin into the funnel. The injection is given three times daily, and is to be retained. In the cases in which I used it, the injections were given on the third day of the period, and usually two days' medication was sufficient to stop the excessive discharge. In fact, by the end of the second day, the discharge had practically ceased. On only one occasion was the injection returned, and I think this was due to nervousness. It was the first one given, and the patient thought that it would act on the bowels. I may say that it has no such action.

The advantages of rectal administration over subcutaneous injection are many. First and foremost there is no danger of infection. This is a very real danger when given subcutaneously, and one that is extremely difficult to eliminate, gelatin being a splendid culture medium. There is no raising of the body temperature, and there is no necrosis, and, according to Tickell, it has the same effect in checking the hæmorrhage when injected into the rectum as when given subcutaneously.

The question may be asked, why, if you give it per rectum, sterilise it? Well, as I have just pointed out, gelatin is such a good soil for the growth of micro-organisms that, in my opinion, it would be taking a great risk of introducing, perhaps, very virulent organisms (anthrax in particular) into the economy. The sterilisation takes place during the preparation, so that there is no extra trouble involved, and if the precaution of sealing the bottles hermetically is adopted, I think there is no danger whatever. I have not been able to use this remedy in many cases. It is a little difficult to carry out. It must be done by a skilled nurse, particular care having to be observed, especially in regard to the temperature, as the gelatin solidifies very quickly, and I find that, in private at all events, patients have a decided objection to rectal medication. I hope, however, to make a further and more extensive trial. I am fully aware that the cases reported are very few, but the uniform success I had with all three tried, I think, warrant my mentioning it.

Of local applications to the interior of the uterus I have no experience except after curettage, and I think that if it is found necessary to apply any medicament to the interior of the uterus in order to stop bleeding, it is infinitely better to curette, and then apply the styptic, and have the scrapings examined by the pathologist.

A number of these cases were seen among Dr. Dauber's out-patients at the Hospital for Women, Soho Square, and I gladly take this opportunity of offering him my warmest thanks for his permission to make use of the material.

I am fully aware, sir, of the many imperfections in this short communication, and feel that I have but touched upon the fringe of the subject. Still, I hope that I have been able to show that there are many conditions of uterine hæmorrhage which are amenable to medical treatment.

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(4) "Diseases of Gall Bladder and Bile Ducts." A. W. Mayo Robson. P. 175.

(5) "On the Pathology and Treatment of Chilblains." Sir A. E. Wright. *Lancet*, Vol. I., p. 303, 1897.

(6) "Styptol, a New Remedy for Uterine Hæmorrhage." R. Katz. *Therapeut. Monatshrifte.* June, 1903.

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THE OUT-PATIENTS' ROOM.

CHILDREN'S HOSPITAL, PADDINGTON GREEN.

Hysterical Torticollis.

By Arthur Edmunds, M.S., F.R.C.S.

Among the out-patients was a girl, æt. 11, who came complaining of her head being on one side and of a large lump in the neck. The history was that she had always been a weakly child; she had suffered from one definite attack of rheumatic fever. The condition of the neck had gradually come on in the past few months. The child was very thin and poorly nourished. Her chest was very flat from before backwards, with a depressed sternum; there was also slight mitral regurgitation. The head was in a position of extreme deformity, inclined to the right, and twisted on itself into the ordinary position of right-sided contraction of the sterno-mastoid; the bodies of the cervical vertebræ could be distinguished at the side of the neck, where they felt at first like a large bony tumour. On entering into conversation with the girl, it was obvious that, although only a little girl, she was hysterical. Her laugh was a giggle, and her movements were erratic, almost choreiform. Mr. Edmunds said that there was here a definite rheumatic history as well as obvious hysteria. The patient was placed on a couch on her back, her attention distracted by talking to her, and an attempt made to correct the deformity. This could not be done quite at once, but the surgeon felt that peculiar quivering of the cervical muscles which showed that the deformity was due to muscles abnormally contracted, but not sclerosed or permanently shortened. With a little patience, he succeeded in getting the head absolutely straight; the swelling produced by the bodies of the cervical vertebræ then disappeared. Unfortunately, when the child was allowed to stand up again the deformity returned. It was obvious, Mr. Edmunds pointed out, that he had to deal with a case of slight rheumatic torticollis in which the hysteria enormously exaggerated the original manifestations. He was inclined to think that this was an example of the very general principle that a functional disorder rarely if ever arises *de novo*, but that the functional symptoms were an enormous exaggeration of the symptoms of a true organic disease. The two might not be present together, for it was possible for the original disorder to have passed away and the functional symptoms to persist. He frequently had children brought to him with a story of injury to the arm, usually quite a trivial one, which had resulted in complete loss of power. The child holds the arm to its side, refuses to allow the parents to handle it, and makes no attempt to use it for any purpose. The first task of the surgeon was, he considered, to eliminate an actual injury such as separation of an epiphysis or fracture of a bone in the neighbourhood of the joint.

This done, the case could usually be cured immediately. When firmly and unhesitatingly grasped, the arm is easily moved, and by distracting the child's attention, persuading it to extend the arm to reach some toy or sweet, the surgeon can obtain complete mobility of the joint. The child's attention is now directed to the limb, and the fact that he can move it driven home. The result of this treatment is usually permanent. Immediately after injury the arm has been painful, and the child has received the mental impression that it would always hurt to move the limb; this impression is removed by demonstrating the contrary. In the case under consideration, the rheumatism, Mr. Edmunds remarked, had practically ceased, but it was thought advisable to give the child a short course of salicylates. He had endeavoured on several occasions, he said, to create the impression in the girl that she could hold her head straight, but in vain; the deformity always recurred as soon as she left the consulting room. Accordingly he gave her an anæsthetic, and put the head up in a position of well-marked overcorrection, fixing it *in situ* by means of a plaster of Paris bandage. This was left on for a fortnight, at the end of which time it was found that the child had lost all tendency to the original deformity—in fact, there was a slight inclination to curvature of the neck in the opposite direction. This tendency had now disappeared, and the child's neck was at present straight; she still, Mr. Edmunds said, required a little discipline occasionally to prevent her relapsing into her old habits, but her condition remains extremely satisfactory. A general tonic treatment had been instituted at the same time with great benefit to her general health. These functional manifestations in children, Mr. Edmunds thought, were far from uncommon; a patient came under his care recently in which the spine was so curved and the muscles so contracted that the case was diagnosed as one of cervical caries with an abscess; a little manipulation, however, enabled the surgeon to ascertain that the disorder was purely functional, and that it was possible to put the head perfectly straight immediately. The correction, too, was permanent. This deformity had followed a trivial punishment at school, and had been increasing in severity for five weeks. These two cases, Mr. Edmunds thought, formed an interesting pair demonstrating the extreme deformities one can find in children, the causation of which is practically entirely functional.

OPERATING THEATRES.

TOTTENHAM HOSPITAL.

OPERATION FOR STRANGULATED HERNIA WITH GANGRENE.—Mr. H. W. CARSON operated on a feeble old man, æt. 84, who had been suffering for seven days from strangulation of a femoral hernia. When admitted to the hospital, the patient was in an extremely weak condition; the pulse was rapid and irregular; he had been vomiting on and off for a whole week, and during the last twenty-four hours his vomit had become feculent. The abdomen was not distended, nor were there any complications such as bronchitis, which might have been expected in a man of his age. It was decided to operate at once, and in view of his condition it was thought advisable to operate under a local anæsthetic. One drachm of a mixture of equal parts of adrenalin chloride and a 4 per cent. solution of eucaine was injected under the skin covering the hernia, and the operation was commenced after a lapse of ten minutes. The sac was extremely thin, and contained a piece of omentum and a small loop of small intestine, which was in a condition of partial gangrene. The constriction at the neck of the sac was divided, Gimbernat's ligament notched, and the intestine drawn down into the wound. The intestine was found to be more seriously damaged at the constricted part than elsewhere, the gangrene having resulted in perforation at that point. The gangrenous loop was incised, tubes fixed into the proximal and distal ends, and the loop of gut attached to the edges of the skin incision. A free discharge of fæcal matter followed from the proximal end, and arrangements were made for this to be carried away through a long tube attached to the tube in the proximal end. Mr. Carson said that the treatment of a strangulation in which the gut is not viable must necessarily depend altogether on the condition of the patient. In a case such as the one he had just operated upon, it was obvious that the most that could be hoped for was to relieve the obstruction for the moment, and this could be best and most rapidly done by adopting the practice of immediate drainage. If, on the other hand, one were dealing, he pointed out, with a patient who was in a condition to stand a somewhat prolonged operation, many surgeons advocated the immediate performance of intestinal anastomosis following upon resection of the affected gut. This can be done through an incision in the middle line of the abdomen or by carrying the original incision upwards and dividing Poupart's ligament. In either case there was a definite risk of infecting the peritoneum. If the patient's condition did not allow of immediate performance of such an operation as this, an artificial anus should be formed by opening the loop of intestine *in situ*, and an operation for the restoration of the continuity of the intestinal canal could be undertaken at a later period. The time at which this must be done depends, he said, not only on the recovery of the patient from his condition of shock and toxæmia, but also on the part of the intestinal canal implicated by the hernia; that is to say, were the portion of gut implicated high up in the intestinal tract it would be necessary to operate earlier than were it lower down; in other words the nearer the implicated bowel is to the lower end of the small intestine the longer is the period which can be allowed before the second operation; the reason for this, Mr. Carson said, was that the patient loses strength very rapidly if the upper part of the intestinal tract is drained by a fæcal fistula owing to lack of nutrition. A ready means of determining the part of the bowel involved lay in the fact that the intestinal wall becomes gradually less bulky from above downwards, while the mesentery, which is thin and semi-transparent in the upper part of the jejunum, becomes thick, opaque and laden with fat towards the lower end of the ileum. With reference to the subsequent operation, Mr. Carson said that there were two methods by which this could be done: the first consisted in opening the abdomen, withdrawing the herniated loop (frequently a matter of some difficulty), excising it, and restoring the continuity of the intestinal canal by an end-to-end or lateral anastomosis. The mortality of this procedure was considerable, and Mr. Carson recommended that a more extensive trial should be given to an alternative method, which consisted in performing a lateral anastomosis between the proximal and distal limbs of the herniated loop within the abdomen, the herniated portion being left with its artificial anus untouched. The success of this latter operation, he considered, depended upon the formation of a large communication (not less than two inches) at the point of the lateral anastomosis; the herniated loop was thus excluded; fæces soon cease to pass through the artificial anus, which will gradually close. The advantages of this operation, he thought, were: freedom from the risk of contaminating the peritoneum, rapidity of procedure, and avoidance of shock.

TRANSACTIONS OF SOCIETIES.

[BRITISH GYNÆCOLOGICAL SOCIETY.

MEETING HELD NOVEMBER 8TH, 1906.

The President, Mr. F. BOWREMAN JESSETT, in the Chair.

SPECIMENS.

MR. J. FURNEAUX JORDAN exhibited the following :—

1. FIBROID OF THE OVARY.

Mrs. S., æt. 59, was sent to me by Dr. Anderson, of the Birmingham General Dispensary, at the end of September last. Two and a half years previously he had diagnosed a definite tumour in the abdomen, had advised operation, but had lost sight of her. He did not see her again until September of this year, when he sent her to me. She was a big woman, and for a long time had been a drinker. Her children were sixteen in number, and it was nine years since she last menstruated. For three years she had been getting larger in the abdomen, and on admission measured 51 ins. round at the umbilicus. The enormous enlargement of the abdomen had for some months caused her distress in breathing, and for over four weeks before admission she had been confined to her bed. Her sufferings were increased by a hypostatic congestion of the lungs and by a large umbilical hernia. She was in constant dread of the latter bursting. The swelling of the abdomen was obviously due to ascitic fluid combined with a tumour which I thought to be ovarian. Her pulse was quick and feeble. I kept her in bed at the Women's Hospital for a few days, propped her up, and gave her strychnine and digitalis. On October 18th I operated. The abdomen was emptied of the ascitic fluid and the specimen you see there removed. I also repaired the umbilical hernia. The specimen proved on section to be a solid fibroid tumour of the right ovary, very hard, with no signs of degeneration anywhere. On the outside, distinct in parts, was a capsule formed of ovarian tissue. A microscopic slide, kindly prepared in the pathological department of the Birmingham University, is on the table showing the fibrous nature of the tumour and the ovarian tissue covering it. The patient has made an excellent recovery.

2. SOFT MYOMA OF THE UTERUS.

Mrs. W., æt. 48, was also sent to me in August last by a General Dispensary doctor, Dr. Moorhead. She had been married twenty-nine years, and had twelve children, the youngest æt. 10. Fifteen months ago her periods began to appear too often—every two or three weeks—and the quantity lost rapidly amounted to a flooding. For six months before admission to the hospital she had been in bed, but in spite of this the floodings were frequent and getting more and more prolonged. For nine months she had felt a "lump" in the abdomen and noticed it getting steadily larger. On admission on October 11th last, she presented all the appearances of one who has had severe hæmorrhages. She could not sit up in bed without feeling faint, her pulse was quick and feeble. On the other hand, she could take her food well and for a week before the operation was taking large quantities of milk. In the abdomen there could be felt a large nodular, distinctly elastic tumour, which bimanually proved to be uterine in origin. On October 18th, I removed the tumour by supravaginal hysterectomy. The operation was not a difficult one. She suffered severely from shock for a few hours, but at the end of twenty-four hours was distinctly improving, and has never gone back again. She got up two days ago and already feels much stronger. On section the tumour was found to contain numerous cavities, some larger and some smaller, which were filled with clear mucous semigelatinous fluid. He did not think it was malignant, and the clinical history did not point to it. After all, the clinical history was more important than the microscope. One usually thought that tumours of the uterus grew slowly. In this case the growth was rapid; the patient had no loss of flesh, and very little pain; she was well nourished and was blanched with hæmorrhage.

Dr. H. MACNAUGHTON-JONES said the first specimen particularly interested him because it was similar to one he had shown in that Society some time since. He understood the woman was a drinker, and perhaps had a cirrhotic liver which would account for the ascites. The second tumour looked like myxomatous degeneration of a fibroid, which had been classified as one of the forms of compound myoma with myxoma.

Dr. HEYWOOD SMITH would like to see microscopical sections of the deeper part of the tumour in order to determine whether the growth of a tumour like that absolutely destroyed all possibility of any further development of ova, as it seemed unusually dense; and also what relation it had to the former active life of the ovary.

Mr. CHARLES RYALL asked how much ascites was present. It was a curious thing that solid ovarian tumours were connected with ascites. Ascites was due to some irritant in the abdominal cavity, such as tuberculous peritonitis. It was a question whether it was due to the absence of any peritoneal covering.

Dr. S. JERVOIS AARONS said that the first specimen was like one removed at Soho Hospital about a fortnight ago, where there was considerable ascites. He was inclined to believe that the presence of a large solid mass was probably the irritant which caused ascites. He did not think it was only a concomitant of malignant tumours in the abdomen. He thought that a large solid mass which was more or less free could cause it. The second specimen had a peculiarly malignant appearance, and he hoped the Society might have an opportunity of seeing a section of it.

The PRESIDENT wished to know whether the liver had been examined. In his experience it was not common to get a large quantity of ascites with solid ovarian tumours.

Mr. J. FURNEAUX JORDAN, in reply, said he thought possibly the ascites might be due to the condition of the liver, but it appeared to be normal. He did not know what the cause of ascites was in a case like that. It was a mystery to him why there should be such an enormous quantity of fluid. There was no pressure on the vessels. He did not know where it came from. If it was desired, he would have a slide made from the interior of the tumour to see if the point raised by Dr. Heywood Smith was able to be cleared up or not. Although the woman had had sixteen children, he should not have thought of saying that her ovary was more active than any other ovary. The condition of the other ovary was perfectly normal. The reason he did not think the second tumour malignant was more from the clinical history and the appearance of the patient than from any microscopic report. He would, however, obtain a pathological report for the Society. He did not agree that this myxomatous condition was common. He had seen numerous specimens of fibroids of the uterus, but had never seen one like this before, and did not suppose that his experience was in any way exceptional. Of course, degeneration of one kind or another was common, but he did not agree that the form which he had presented was a common one.

Dr. J. H. SWANTON read notes on a specimen of

CYSTOMA OF OVARY.

with thyroid tissue present, which will be found on page 551.

Mr. CHARLES RYALL exhibited a specimen of

HYPERTROPHY OF THE VULVA AND CLITORIS.

occurring in an old syphilitic patient, with photographs. It was removed from a female, æt. 55, an in-patient of the Lock Hospital, under Mr. H. A. Shillitoe, who had kindly asked him to see her. On examination he found she had a hypertrophied condition of the vulva, with a peculiar hypertrophied pendulous condition of the clitoris. It was difficult to obtain a history. Her primary symptoms must have occurred years ago. She had a family, and the children were healthy. On

making an examination, the clitoris was found much elongated, and club-shaped. On one side it would be noticed that the labia were very much enlarged; there was a condition of pseudo-elephantiasis. All around the buttocks there was considerable induration, a condition which always indicated stricture of the rectum, and always one sort of stricture, namely, syphilitic stricture. The whole perineal region of the buttocks was a mass of inflammatory tissue, with openings all round from which pus oozed. The stricture of the rectum was not a very extensive one.

Above the stricture the bowel was quite healthy. He had the patient transferred to the Cancer Hospital. There she was photographed and the mass was removed. Microscopically it turned out to be a granuloma, evidently of syphilitic origin. He was not surprised at that, because at the Lock Hospital one came across a great many cases of hypertrophy of the vulva in old tertiary syphilitic patients, hypertrophy which very often became pedunculated, and it was not uncommon to find the clitoris enlarged and quite pendulous. In that particular case, the patient noticed the condition eleven years previously, but lately it had become very much worse, and there was a great pendulous mass hanging down between her legs, and on walking it got rubbed and became irritable and sensitive, so she was unable to take much outdoor exercise. It consisted of granulation tissue, partly chronic and some recent.

Mr. HARRY OVERY asked Mr. Ryall if he had found hypertrophy of the vulva associated with gonorrhœal discharge only. He had seen one case in which there was no evidence that one could find of syphilis, and the hypertrophy of the vulva was practically as large as a newly-born child's head. He wished to know whether Mr. Ryall had seen any cases in which syphilis was not a factor.

Mr. CHARLES RYALL said he had never seen hypertrophy of the vulva associated with gonorrhœa only, and where it existed would be suspicious that the patient had syphilis as well as gonorrhœa. He found that in the female syphilis failed to show the classical symptoms which one was accustomed to find in the male. For instance, it was very difficult in many of those cases to find the primary sore, and even if one found it, or if one came across extensive hypertrophy of the vulva—sometimes it was very extensive—that patient might not present the cutaneous symptoms which one was accustomed to find associated with the secondary stage of syphilis, nor did one find in the female that glandular enlargement which was also associated with the secondary stage of syphilis.

Dr. S. JERVOIS AARONS read notes on the

MEDICAL TREATMENT OF UTERINE HÆMORRHAGE,

which will be found on page 552.

In the discussion that followed,

The PRESIDENT said their thanks were due to Dr. Aarons for his excellent and interesting paper. He wished that the author had been more explicit as to the doses he had given, and how he employed the gelatine.

Mr. FURNEAUX JORDAN was really extremely grateful for the hints and advice which Dr. Aarons had given. The author's medical treatment of uterine hæmorrhage was very largely different from his own: he had relied upon ergotine and hydrastin. He had never heard of the treatment of injecting gelatine into the rectum.

Dr. MACNAUGHTON-JONES remarked that the difficulty in arriving at a solution of the problem as to whether one was to cure hæmorrhage by operation or by therapeutical means was the crux of the whole situation. He was glad to hear Dr. Aarons say that he had given those cases quite apart from any question of those forms of hæmorrhage which must be treated solely by operation. Many of the drugs which the author used, he had himself used. For some fifteen years or more he had been using hydrastin; he had used it in combination with stypticine and ergotine, and had generally found the combination to be very useful. Throughout the long list of cases given by the author he noticed that only on three occasions had he used the hot douche. He thought that that alone was a wonderful practical lesson. He did not know of anything which had been so abused in the past, and which possibly had done more mischief, than the hot douche used up to 120°, the patient being given her can to use *ad libitum*. He must confess that he was an advocate for curettage in most cases of hæmorrhage which did not quickly yield. One plan which he adopted had generally given him good results—the application of chromic acid in combination with curettage, from 30 to 40 grains of chromic acid to an ounce of water. In cases of endometritis that was a most valuable method of checking hæmorrhage.

Dr. HEYWOOD SMITH asked the author if he had found that stypticine had produced an increase of hæmorrhage. He had administered it to an unmarried woman who had had profuse menstruation from her earliest years, and it had produced it in still greater quantity. She had her last two periods every fortnight instead of every month. However, his impression was that a patient got wearied and did not persevere with it long enough.

Dr. BENNETT said the paper would be much more beneficial if one or two columns were added to it. They were given the condition of the patients, the cause, and the treatment, and the result, but they were not given the doses. He was speaking of those where drugs were used. It would also be of advantage if the time of treatment were put down, and the result, and how long a particular drug was continued before there was cure or improvement. In that way they would get the data for the consideration of whether medical treatment was superior to surgical treatment.

Dr. NEPEAN LONGRIDGE thanked the author for his excellent paper. In looking through the list of cases, he noticed Case 21, a woman, æt. 22, who suffered from menorrhagia with uterus infantilis. Surely that was a very unusual condition. Such patients suffered from amenorrhœa. He was not aware of the microscopical appearance of those uteri, but in his work in his hospital, he had seen many uteri of still-born fœtuses. He made sections from the uterus of every stillborn female child, and had been very much astonished in finding how extraordinarily vascular the uterus was. He would like to ask Dr. Aarons whether the uterus in a woman æt. 22 partook of those characteristics at all. There was one other criticism he wished to make. They were told that the cases were either cured or checked. What was the exact difference between a check and cure in a case of menorrhagia, because if a woman had menorrhagia there was not much difference between checking it and curing it.

Mr. CHARLES RYALL stated he found that rest was an important factor. The hæmorrhage was not cured, but it could be checked by rest alone. It was very interesting to note that the gelatine ought to be sterilised.

Dr. HODGSON said he had found on several occasions when the drugs which had been mentioned failed, that

tincture of cannabis, added to any of the other hæmostatics, would stop hæmorrhage almost magically. With regard to the hot douche, which Dr. Macnaughton-Jones had spoken of, he must say in some cases there had been sub-involution which had been curetted, and, assuming they were troublesome cases, he had used very hot water, much hotter than had been mentioned. He had used it at 135°, and had reduced the uterus two inches in size, and had never found any trouble afterwards—no pains or anything else, and scarcely any loss at all. With regard to nitric acid, that was a very useful drug, but one could not get it distributed in the interior of the uterus so well. It was better where one got a granular condition round the os. Another medicine sometimes used was solid nitrate of silver, 15 grains, but in his experience it was not successful.

The PRESIDENT said that the subject of the paper was uterine hæmorrhage, but the author did not state the cause of the hæmorrhage. He would ask Dr. Aarons whether he had examined the uterus, after he had treated the cases for a short time, and they had not responded to the treatment, for submucous fibroid or a tuberculous condition or anything of that kind, because if such conditions existed, no great benefit could be derived from drugs even if used for a very long time, or if there were benefit, he fancied that so soon as the patient began to get about again the hæmorrhage would probably recur. He would also like to know how long the author carried on his treatment; whether the patients were kept in bed the whole of the time; if, after leaving off the treatment for a few months, the hæmorrhage returned again; and whether there had been any return of hæmorrhage later on in life.

Dr. AARONS, in reply, said that with regard to hot douching, the only cases where he used it were cases of cellulitis, and even then it was not used with a view of reducing the hæmorrhage, but with a view of reducing the inflammatory conditions. He quite agreed that the hot douche had been vastly overdone, at all events so far as hæmorrhage was concerned. With regard to endometritis his impression was that most of it now was septic. In most of those cases it was better to try drugs first of all, and curette afterwards. He would rather try the effect of drugs before resorting to any operative treatment in a case of endometritis. He agreed with what had been said with reference to adenoma. He only discovered the patient had adenoma after treatment. She was a woman æt. 50, and her hæmorrhage was profuse. She had two or three periods after curetting, which were just as bad as before the curetting, and she reacted marvellously to the gelatine. There was another point about the case. She was æt. 50, and was probably near the menopause, and that might have had something to do with it. He had seen her afterwards when she had passed the menopause, and there had been no return. He thought adenoma was very closely related to carcinoma. With regard to stypticine, he had only used it on one or two occasions, but he saw no reason why it should increase the hæmorrhage. He could not answer that point. In reply to Dr. Bennett, he had mentioned the doses which he had given in the paper, except, of course, the hydrastin compound, which was a special formula. That was

HYDRASTIN CO. STYPTICIN.

Hydras Hydr.	¼ gr.
Ergotine	½ gr.
Cannabis Tan.	½ gr.
Stypticin	¼ gr.

Ergotine he had mentioned in the paper. He had also mentioned the gelatine — about 9 ozs. injected into the rectum. The patients were treated for three to six months. If they did not react in that time, then the uterus was examined. All those cases reacted. He had a great many cases of hæmorrhage, which, of course, were operated on at once; that was, they were not treated by drugs; but those were cases which he thought, from the clinical aspect, would react—cases of hæmorrhage after abortion where the uterus was empty. One often got subinvolution of the uterus, and there the compound which Dr. Macnaughton-Jones had suggested, of hydrastin, was one of the most valuable medicines. In reply to Dr. Longridge, the uterus infantilis was rather puzzling. The patient was sent to him first of all to know if she would probably become pregnant, as she wanted to be married. He said he thought it was extremely unlikely, with a uterus such as she had. Three or four months after that her doctor had sent for him again, saying that she was flooding. He could hardly believe it, but the doctor said, "There is no doubt about it; you must see her." He did so, and she *was* flooding. She had been in bed for the best part of six days and had used something like sixty diapers. He had not the remotest idea what the cause was, because he had not had a chance of examining the uterus, but it was probably constitutional. She had married since. He had not heard any more of her. With regard to the difference between check and cure, he had put down those cases as checked where it was kept under control while the drug was administered. In some of the cases the drug kept, not hæmorrhage, but the menorrhagia, within due limits. He had called those cases cures where, after taking the drug for three or four periods the patients had not required it again, and had normal periods without it. Some of the patients had rest. The cases of fibroid menorrhagia had rest. There again, menorrhagia with fibroid was a case for operation, but those were cases which were either operated on later, or refused operation. They were not treated medicinally with a view to avoid operation. He had only mentioned sterilisation of gelatine because he believed in two fatal cases at Guy's anthrax was found in the solution. But of course, if gelatine was used in that way, it was sterilised in the process of preparing it. He had used Cannabis indica, in the preparation which Dr. Macnaughton-Jones had mentioned. He had seen most of the cases after some four or five months, and these had remained practically free from hæmorrhage.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF SURGERY.

President—HENRY R. SWANZY, P.R.C.S.I.
Sectional Secretary—E. H. TAYLOR, F.R.C.S.I.
MEETING HELD FRIDAY, NOVEMBER 2ND, 1906.
The PRESIDENT in the Chair.

EXHIBITION OF CASES AND SPECIMENS.

AFTER some introductory remarks by the President, there was an exhibition of cases and specimens.

Mr. J. L. KEEGAN exhibited a patient, æt. 78, upon whom he had performed the operation of suprapubic prostatectomy. He also exhibited a boy, æt. 7, whom he had trephined for intracranial abscess. *Resume* of case:—Boy, æt. 7, admitted into Jervis Street Hospital, April 26th, suffering from an extensive scalp wound caused by his having been knocked down by a tram. He had not lost consciousness. The wound was treated by resident staff, and sutured. Two days after this the scalp began to slough, and suppuration established itself in spite of free drainage. On May 13th, nearly three weeks after the accident, his temperature rose to 100°, pulse 115, and he was found in a convulsed condition. The first fit began by twitching of the facial muscles on the side opposite to the wound—viz., the left side; the left hand was contracted; left leg and arm in a clonic condition; patient unconscious. The fit lasted for about ten minutes, passing off, leaving patient pale and weak. Between May 14th and 16th he had three more fits, and had begun to lose power of the left arm and leg. On May 17th he had as many as fourteen seizures. On May 18th the scalp wound was opened, exposing the bone over the Rolandic area; it looked dry and yellow, evidently necrosed. A trephine was applied

over this area of bone, and as the instrument worked inwards pus welled up. On removal of the piece of bone a large collection of pus was evacuated; there was no pulsation in the area of brain substances exposed, but it was very tense. The tense dura mater was incised and a trocar passed downwards and inwards into the brain substance. Nothing escaped but a little blood. The cavity between the dura mater and bone was drained by strips of iodoform gauze. Temperature dropped from 102° to 100°, but, as he had two fits during the night, on the following morning more bone was removed with bone forceps and drainage continued. May 21st—Pulsation visible over affected area; no more fits; temperature 100°. May 21st to 27th—Normal temperature; no fits; patient improved so rapidly that he was allowed out of bed. June 8th—A large graft of skin was taken from the boy's thigh and applied over the raw surface; this took well, and completely covered in the brain substance. Present condition—There has not been any recurrence of the fits, all signs of paralysis in limbs have disappeared, and the brain is covered by a firm skin covering. The intracranial suppuration was evidently produced by a septic osteomyelitis secondary to suppuration in scalp. There was possibly a fissured fracture of the skull, through which the pus travelled, causing the intracranial abscess to form.

The case was discussed by Mr. R. C. B. MAUNSELL, who alluded to another case of a boy from whose skull a large part of the frontal bone had to be removed on account of severe injury. A large pulsating area remained after the healing process was completed, but no subsequent operation was undertaken, and no harm resulted. He would therefore advise against future intervention in Mr. Keegan's case.

Mr. ROBERT WOODS showed a case of a woman whose throat had been accidentally cut, fifteen months ago, through a motor car colliding with a tram car. All the tissues from the front of the neck to the vertebral column had been severed by the broken edge of a pane of glass. He had found, on examination, that a cicatricial diaphragm grew horizontally across the pharynx, behind the hyoid bone, shutting off the mouth and pharynx above from connection with the larynx and gullet below. Respiration was carried on through a tube inserted in the thyro-hyoid space, and feeding was only possible by removing the breathing tube and passing an œsophageal tube through the opening. A small opening, large enough to admit a fine probe, was found to exist in the centre of this diaphragm. The problem to be solved was how to enable the woman to speak so that she might carry on her occupation as a typewriter. Mr. Woods dilated the opening by a series of bougies till its diameter was sufficiently great to hold a tube through which she could breathe comfortably. This could not be put in without making some provision for the evacuation of the saliva, which was constantly trickling into her pharynx, and which, before she came under his care, lay in a pool over the pharyngeal diaphragm. Mr. Woods showed an apparatus by which he overcame these difficulties, and which consisted in a double tube, bent in the middle nearly to a right angle, so that it could be inserted through the thyro-hyoid opening and then upwards through the cicatricial diaphragm. The patient breathed through the large tube, while the smaller one was used for the purpose of sucking away the saliva by a suction apparatus attached to the patient's belt. The apparatus was found to work quite satisfactorily; the patient could talk, breathe and sleep very well, and was not in the least troubled by saliva trickling into her larynx.

The case was discussed by Sir ARTHUR CHANCE and Sir Kendal Franks, who was present as a visitor.

Mr. R. A. STONEY exhibited a case of malunited supra-malleolar fracture after operation. *Resume* of case:—Man, æt. 40, admitted to hospital last Christmas. He was thrown off a horse ten months previously and sustained a supra-malleolar fracture of both bones of the right leg. The bones had united in bad position, with outward displacement of the foot, causing great pain when the patient walked. At the operation callus was cut through, and the bones re-fractured. The foot was then brought into position and the tibia wired. Patient returned a month ago complaining of pain, on pressure, on the inner side of the leg above the ankle. This was found to be due to the wire, which was immediately under the skin. After removal of this the patient was able to walk perfectly without pain.

Mr. STONEY also exhibited a cancerous growth of the rectum removed from a man, æt. 60. It formed a large cauliflower-like mass, involving about three inches of the posterior wall of the rectum, and invading the region of the sphincters below. It was removed by the sacral route.

Mr. HAUGHTON, in discussing the case, enquired of what material the wire consisted, and why it caused trouble in Mr. Stoney's case. Great care was necessary in the sterilisation of wire employed for suturing bone, and it was his practice to keep it in the sterilising apparatus until required.

Mr. T. E. GORDON alluded to a similar case in which he had employed silver wire for suturing purposes. Subsequently it pressed against the skin, and had to be removed, but it was perfectly aseptic.

Mr. JAMESON JOHNSTON showed a case of a youth, æt. 18, who stated that he first noticed something wrong with his right hip about nine months ago, and which has been gradually getting worse. There never has been any pain in the hip, but the patient complains of pain in the inner side of the thigh and knee. At present there is some wasting of the thigh, the gluteal fold and trochanteric fossa are well marked; the great trochanter is displaced upwards at least two inches. There is some eversion and adduction; the thigh can be fully extended and almost completely fixed; adduction can be increased but abduction is impossible. These passive movements cause practically no pain. Skiagram shows a bending of the neck of the femur and the top of the great trochanter almost on a level with the acetabulum. Mr. Johnston considered the case to be one of coxa vara adolescentium,

Mr. MAUNSELL enquired if Mr. Johnston considered coxa vara as an entity in itself. It seemed to him either to result from tuberculous disease or rickets. It should not be regarded as a special disease.

Mr. EDWARD TAYLOR described a case under his care in Sir Patrick Dun's Hospital, which presented some features very similar to Mr. Johnston's. It was evidently tuberculous in nature. He had been very much interested in the skiagram of the hip-joint exhibited by Mr. Johnston. It gave him the impression that the head of the femur was partially dislocated.

Mr. HAUGHTON also discussed the case, and expressed the opinion that the head of the femur was partially dislocated upwards. Assuming this to be the case, the question arose, was the condition really coxa vara or erosion of the acetabulum as occurred in tuberculous disease.

Dr. EDWARD J. WATSON considered the hip condition the result of erosion of the acetabulum.

Mr. JAMESON JOHNSTON, in reply, stated that he merely employed the term coxa vara to signify a deformity. He found it difficult to associate tuberculosis with the case, as the boy had never had pain in the hip-joint.

Mr. HAUGHTON showed two patients in both of whom both femora had been fractured simultaneously. The first, a boy æt. 7, a year ago was pushed against a passing lorry, and both legs passed through the spokes of the wheel, and in this position rotated with the wheel. The right femur was broken in upper third (simple), and the left in lower third (compound). In addition, most of the ligaments of left knee were ruptured, and there were two compound fractures of left leg (both bones). Further, there was a severely lacerated wound two-thirds round leg just above ankle, almost amputating it, but circulation was present in

the toes, so the foot was spared. The boy can now run about vigorously, and stand on either leg alone, and has full motion in his knee-joints. (Skiagrams illustrating this case were handed round). The second case, a man, æt. 62, two years ago was wheeling a barrow of heavy stones from a sand-pit, when some tons of loose gravel and sand collapsed on him, crushing him to the ground. There were comminuted fractures of both femora in lower third, compound on left side, and rupture of internal lateral ligament of left knee. This man can now walk about strongly, and bear his full weight on either leg. His right femur was ununited three months after the accident. Torn muscle between fragments was diagnosed and verified by operation, when the ends of bones were chiselled into a concave and convex V, and a three-inch iron screw passed through them. Primary union by bone followed, and he still retains the screw *in situ*. The treatment in the two cases was similar. The limbs were scrubbed for twenty minutes with soap and hot water, followed by ether and alcohol (or biniodide in alcohol), and the compound wounds douched for twenty to thirty minutes with normal saline alone at body temperature, several gallons being used. Silkworm gut drains were then passed into all the wounds, and sterilised dressings applied. An anæsthetic (ether) was given, and plaster of Paris bandages at once applied from the toes to the axillæ, covering both legs and trunk, leaving a suitable cleft for urination and defæcation. During the plaster application, extension was maintained in the boy's case by Dr. Halahan's apparatus, and in the man's by a modification of Professor Kocher's. Mr. Haughton considered the good result obtained in each case to be due to—first, to a purely aseptic technique in dealing with internal parts of accidental compound wounds; and secondly, to the excellent fixation afforded by primary plaster of Paris, which methods are his routine practice.

Mr. Edward Taylor, in discussing Mr. Haughton's cases, stated that while he fully realised the excellent results which had been obtained, and for which Mr. Haughton deserved to be congratulated, it was a question whether the employment of plaster of Paris, as a rule, immediately after the occurrence of fracture was advisable. In Mr. Haughton's hands, and in the hands of other hospital surgeons, cases so treated had done well, but in the hands of less skilled individuals such treatment might be attended by considerable risk. His own practice was to place fractured limbs in splints for a few days before applying plaster of Paris.

Mr. Lentaigne expressed himself strongly in favour of the application of plaster immediately after the injury, and had made it a practice for years with most satisfactory results.

Mr. Johnston believed it was better to wait for the subsidence of swelling before applying plaster.

Mr. R. C. B. Maunsell exhibited three specimens of gastric carcinoma which had been excised.

Mr. W. Stevenson exhibited a necrosed humerus removed as a sequestrum, and a skiagram showing the sequestrum *in situ* before the operation.

Mr. Wheeler exhibited a loose body removed from the knee-joint.

Mr. W. Taylor exhibited a carcinoma of the cæcum and ascending colon which had been removed.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

Meeting held November 7th.

The President, Dr. J. O. Affleck, in the Chair.

Dr. Allan Jamieson showed microscopic specimens of Darier's disease.

Drs. Alex. Bruce and Harvey Pirie showed microscopic specimens of the intermedio-lateral tract of the cord.

Dr. T. W. Dewar showed a case of lupus vulgaris of thirteen years' duration healed in forty days under treatment with hydrogen peroxide locally and intravenous injections of ethereal solution of iodoform. Very many methods of treatment had previously been tried, including a prolonged course of Finsen light. Koch's old Tuberculin had given a very marked reaction. The benefit received was ascribed rather to the injections of iodoform than to the local application of peroxide.

Dr. Allan Jamieson showed a case of Darier's disease in a woman. The bodies described as psorosperms had been discovered in microscopic sections of the skin, but their relation to the disease was doubtful.

Dr. Byrom Bramwell showed a male, æt. 42, suffering from ataxia to so marked a degree as at once to suggest tabes. Further examination, however, showed that the patient suffered from multiple sclerosis. The man was so ataxic that he could scarcely walk. He had no history of syphilis, no lightning pains, no loss of the pupillary light reflex. The knee jerks and achilles jerks were exaggerated, there was ankle clonus, double Babinski phenomenon, tremor, and nystagmus. The exaggeration of the tendon reflexes had diminished in degree during the past few months. The explanation offered was that in this case one of the patches of sclerosis was implicating a large area of the posterior columns in the lower part of the cord.

Dr. George Mackay showed two cases of hereditary optic atrophy. In both cases there was visual defect of several months' duration with changes in the optic discs and central scotoma. In one case a family history of blindness coming on in early adult life had been traced through three or more generations; in the other the patient's uncles had also been affected. The disease affected males chiefly, and was transmitted through the female line.

Dr. Edwin Bramwell showed a case of juvenile general paralysis in a boy of 16. The patient seemed to have been slightly backward before the onset of his present symptoms, which had originated eighteen months before after a fall on the head. They consisted in tremor, failure of memory, inco-ordination, loss of the light reflex, and exaggeration of the knee jerks. The tremor was well marked in the tongue and face muscles, and the speech was characteristically slurred. An interesting point was the absence of any history of congenital syphilis, or signs of it in the facies, teeth, eyes, &c., of the patient. Yet on examining the spinal fluid a marked lymphocytosis was present, which pointed to a probable syphilitic origin.

Mr. Stiles showed (1) a patient after enterectomy for perforated typhoid ulcer with diffuse peritonitis. The nature of the case was only ascertained at the operation, when the ileum was found to be perforated, and the thickened Peyer's patches were felt. About 6 ins. of bowel was resected, and a Paul's tube inserted. (2) A man suffering from multiple neuro-fibromatosis (Recklinghausen's disease). A large tumour had been removed from the buttock. This had been present as long as the patient could remember, while the smaller tumours scattered over the body had only developed, and were still developing, within a comparatively recent period. The tumours implicated the cutaneous nerves, not the main trunks. With two exceptions, which had been removed, they were painless. There was one tumour on the palm of the hand—a somewhat rare situation. (3) A case of complete facial paralysis following fracture of the base of the skull. Examination of the ear showed that in all probability the seat of the lesion was the temporal bone. As it was probable that the nerve had been completely torn across the Fallopian canal, and that new bone had been thrown out which would prevent reunion, Mr. Stiles thought the case a suitable one for transplanting the spinal accessory nerve on to the divided fascias. The slight paralysis of the trapezius which would follow would not interfere greatly with the usefulness of the arm (in this case the left), provided that the branches from the cervical nerves, and the nerves to the rhomboids were left undisturbed.

Dr. T. D. Luke exhibited Harvey Hilliard's new regulating chloroform inhaler, by which chloroform

vapour varying in concentration from ·75 to 4·5 per cent. can be administered. After a short account of the various apparatus which had been employed previously, he pointed out the advantages of the new pattern, and finally pleaded for the necessity of accurate dosage in using so active a drug as chloroform. Few students knew, he said, that 25 minims of chloroform evaporated was enough to produce anæsthesia. One great advantage of the inhaler over the drop method was that the administrator inhaled no chloroform. There was also no waste of the drug. With the inhaler he could induce anæsthesia in from four to six minutes.

Mr. ALEXIS THOMSON exhibited Roosevelt's clamp for gastro-intestinal anastomosis. It is, in effect, a double clamp, by which the stomach and bowel are approximated and held in a convenient position by a single instrument. The clamp is particularly useful when the mesentery is thickened and short, or where the cardiac part of the stomach has to be dealt with.

Drs. A. BRUCE and HARVEY PIRIE read a paper entitled

A PLEA FOR THE STUDY OF THE INTERMEDIO-LATERAL TRACT OF THE SPINAL CORD.

The paper was illustrated by a series of lantern slides, demonstrating the points raised in the paper, a full abstract of which will be found on page 550.

Dr. BYROM BRAMWELL congratulated Dr. Bruce on his work. The paper was one which would do much to stimulate interest. He thought it must now be regarded as almost proved conclusively that the intermedio-lateral tract was the centre for the sympathetic fibres. It was impossible to draw far-reaching conclusions from two cases, but it certainly was a remarkably striking coincidence that in both of these, lesions had been found by Dr. Bruce where from his previous researches he had anticipated them.

Prof. CUNNINGHAM discussed the paper from the anatomical point of view. He was now convinced that the tract must be regarded as the special centre for the efferent sympathetic fibres. Formerly, looking at it as an anatomist, he had been struck by the fact that the tract was, as it were, squeezed out of existence in the cervical and lumbar enlargements by the grey matter of the anterior horns. Now, he thought, its peculiar distribution could no longer be explained on this view, but corresponded with the distribution of the sympathetic fibres. He thought it would be admitted that Lockhart Clarke's work, done with imperfect methods, more than fifty years ago, had proved wonderfully accurate through the test of time.

The following were elected office-bearers for the ensuing year :—President : Dr. James Ormiston Affleck; Vice-Presidents : Dr. George Hunter, Prof. Greenfield, Dr. Byrom Bramwell ; Councillors : Prof. Chiene, Mr. Alexis Thomson, Dr. R. A. Fleming, Dr. F. D. Boyd, Prof. Harvey Littlejohn, Dr. Aitchison Robertson, Dr. Heppie Paterson, Mr. William Guy ; Treasurer : Mr. J. W. Dowden ; Secretaries : Dr. Lovell Gulland, and Mr. David Wallace ; Editor of Transactions : Dr. William Craig.

LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD THURSDAY, NOVEMBER 8TH, 1906.

The PRESIDENT, MR. FRANK T. PAUL, F.R.C.S., in the Chair.

DR. HUGH R. JONES read a note on

THE DEATH-RATE OF THE CENTRAL WARDS OF THE CITY OF LIVEROOOL.

He pointed out that, despite a large expenditure of money and the demolition of much insanitary property, and the building of many model dwellings, the death-rate of Scotland ward had not fallen as much as the death-rate of all England and Wales. The deaths of children under five years of age accounted for half the death-rate. Organised sanitation affected only early maturity. The density of population in Scotland ward was greater now than it was 15 years ago. He recommended the opening up of closed courts, the utilisation of school yards as playgrounds, &c., rather than a waste of public money on wholesale demolition. The landlord was to blame as well as the sanitary authority for not enforcing the wholesome provisions of the Housing Acts. He declined to discuss the social aspect, inasmuch as he believed the sanitary authority had a definite duty imposed upon it by the legislature.

After a few remarks on the subject by Dr. Wm. Carter and Dr. R. Caton,

Dr. F. W. PARKER YOUNG showed two patients who were under treatment for phthisis by the intravenous injection of formalin.

Dr. JOHN HAY, who had seen the cases before treatment, thought some improvement had taken place since he had last examined the patients.

THE RECENTLY DISCOVERED HEATLH TEMPLE OF HIPPOCRATES AT COS.

Dr. RICHARD CATON delivered a most interesting lecture on the above subject. The lecture was profusely illustrated by limelight views of the island, and of the recently excavated remains, and by plans and "reconstructions" of the ancient temple and sanatorium.

The lecturer said that the site, about two miles from the modern town of Cos, had been so changed by earthquakes, by the growth of vegetation, by the destructive work of the lime-burner, and by the erection in mediæval times of churches and mosques, that all traces of the magnificent Coan sanctuary had disappeared, and the association of the place with Asclepios had remained absolutely unknown for centuries. Prof. Rudolf Herzog, of Tubingen, began to investigate this site three years ago, and had been rewarded by the discovery of highly interesting remains of the ancient temple and precinct. To him and his fellow workers belonged the whole of the credit of the excavation. The temple precinct consisted of three terraces arranged in steps on the mountainside. A vast number of ancient earthenware pipes brought water to the baths and fountains, probably from the spring of Hippocrates, and from the celebrated red water, or iron spring, a couple of miles higher up in the mountains. The north side of the quadrangle contained many rooms, dispensary, library, and rooms for teaching purposes, for Cos was a medical school. About the centre of the second terrace there stood a huge altar, reminding the visitor of that of Pergamon, though on a smaller scale. This was interesting as being the scene of the fourth Mime of the Greek poet Horondas. The views from the temple commanding the mountains and plains of Cos, the blue Ægean, the islands and the hills of Asia Minor, were most striking. The sanctuary had no theatre or stadium, those of the town of Cos being easily accessible. The sacred grove of cypresses surrounded the upper part of the temple on three sides.

ULSTER MEDICAL SOCIETY.

THE annual dinner of this Society was held in the Medical Institute, Belfast, on Thursday evening, November 15th, the President, Dr. David Gaussen, in the chair. About sixty members were present, and the guests included Mr. Swanzy (President of the Royal College of Surgeons, Ireland), President Hamilton (Queen's College), Professor Schafer (Edinburgh), and Prof. Symington (President of the Ulster Branch British Medical Association). After the toast of "The King" had been honoured with the usual loyalty, the President proposed the toast of "The Lord Lieutenant and Prosperity to Ireland," coupling with it the name of Sir John Byers, whom he congratulated in the name of the Society on his recent honours.

The next toast was "The Irish Medical Schools," proposed by Dr. R. W. Leslie in a few well-chosen words, and responded to by Mr. Swanzy and Prof. Symington in speeches which gave rise to much interest and private discussion among the members. Mr. Swanzy, after disclaiming any right to speak for the Irish schools generally, took the opportunity of discussing the relation of the Belfast Medical School to Dublin, and specially to the College over which he presides. He had observed that the Belfast men who did not take the degrees of the Royal University

generally took a Scotch diploma, and he expressed a strong feeling that this was not as it should be, but that the Irish Colleges were worthy of the support of all Irishmen, and were not merely Dublin institutions. He said that he had heard various explanations, but nothing which he could call a reason, and begged them, if they knew of any difficulties or objections, to state them, so that they might be answered and met if possible. Prof. Symington, who followed, answered several of Mr. Swanzy's points. He said that the teachers of the Belfast School tried to get all their students to go for a University degree, and it was only those few who could not affordthe necessary time or expense who went up for the diploma of the Colleges. As regards any undue preference for Scotland, he pointed out that in the College calendar particulars were given first of the Royal University, then of the licensing bodies of Ireland, London and Scotland, in the order named, and he suggested that if the Irish Colleges wished to attract more Northern students they might do so by appointing a few more Northern examiners, as at present they had only one.

Prof. Sinclair proposed the toast of "Our Guests," with the names of President Hamilton and Professor Schafer, and referred to the successful efforts of the former in raising the "Better Equipment Fund" of Queen's College to £70,000. In replying, Dr. Hamilton said he wished to thank the medical men of Belfast for their most generous response to the appeals on behalf of the fund referred to, as he believed the generous example set by the medical graduates had much to do with the hearty support accorded to the fund by the lay public. Professor Schafer made the speech of the evening, and gave the members subject matter for thought for many a day to come. After referring to some recent researches on the influence of the pituitary body on diabetes insipidus—a subject-connected with that on which he had formerly addressed the Society, and which he wished to supplement, he plunged boldly into the stormy waters of the Irish University question, as it concerns the North. He expressed in the strongest manner his belief that the future evolution of the Belfast school must be on the lines of an autonomous university, with its own degrees, its own examiners, and its own standards. Why, he asked, should not Belfast have its own university as well as Leeds, Sheffield, and Birmingham? He knew that there were difficulties, religious and political, in the way, but difficulties were made to be overcome, and if we wanted a university we should get it. His remarks were received with enthusiasm by a small section of his audience, who were delighted at this independent support for their generally unpopular ideals. The majority, howeve, listened in respectful silence, as they still cling to the teaching of the late Dr. McKeown, the founder of the Royal University Graduates' Association, who dreaded an Ulster University lest his pet bogey of Denominationalism should find a home in it, and who had a touching faith in the possibility of improving the Royal University so as to make it a thoroughly satisfactory institution.

"The President and Secretary of the Ulster Medical Society" was proposed by Dr. McKisack, and responded to by those gentlemen. During the evening songs and recitations were given by Drs. McKenzie, MacIlwaine, Calwell and Morrow.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Nov. 18th, 1906

Sciatica.

Years ago the treatment of sciatica by injections of medicinal agents was recommended by Luton (1863), who employed morphia and even nitrate of silver. Since then numerous authors: George, See, Dieulafoy, Albert Robin, injected in the neighbourhood of the sciatic nerve solutions of antipyrine, methylene blue, phenic acid, chloroform, distilled water, concentrated solutions of the glycerophosphates, etc.

Within the last few years, M. Lannois employs systematically subcutaneous injections of artificial serum over the painful points, the liquid, to which is added two drachms of sulphate of soda per quart, is injected warm in drachm doses every two days.

M. Barthelemy, of Nantes, follows the same practice but with larger doses (5 drachms), and makes three injections at one sitting: the first as deep as possible at the point of emergence of the nerve, the second, behind and below the great trochanter, also deep, and the third more superficial in the postero-external region of the thigh. The two first injections are perfectly painless, but the third smarts a little. No tissue swelling nor rubefaction is observed after the injections.

The patient complains at first of a sensation of numbness in the limb for the first two or three hours after the injections, when it disappears giving place to a marked sensation of relief and the improvement is such that the patient returns for a renewal of the treatment. M. Barthelemy repeats the injections every ten days, but sees no reason not to renew them more frequently. He thinks also that sea water might take the place of the ordinary artificial serum.

Several authors have published cases of successful treatment by injections of cocaine into the medullary canal in the lumbar region, but this treatment is not always easy for the general practitioner and is not without a certain amount of danger, while the serum injections are inoffensive and frequently effect a cure.

The surgical treatment consists in the stretching of the nerve, which had been practised for years, but to-day more or less abandoned. M. Pers reports two successful cases from simple exposure of the nerve. He made an incision between the great trochanter and the tuberosity of the ischium. As soon as the nerve was found he isolated it, and examined it to see if it had retained its normal white colour, and was not fixed by adhesions. In both cases the nerve was red and fixed. The incision was prolonged until the nerve was found white and free. The red colour was due to conjunctive tissue which enveloped it. The covering was detached and the nerve resumed its normal aspect.

The simple method of exposing the nerve (neurolysis) is claimed by M. Pers as superior to the classical forcible stretching by which its fibres are ruptured.

GERMANY.

Berlin, Nov. 18th, 1906

Substitution of Great Toe for Lost Thumb.

At the last meeting of the Medizinische Gesellenschaft Dr. Krause showed a young man for whom a great toe had been substituted for a thumb. The thumb had been lost in an accident, and only about 1.5 cm. of the stump of the bone left. The patient was very much handicapped in his work through the loss. After the proposal of Nicoladini, who had made use of the second toe, which was atrophied and useless for the purpose, Krause proposed to utilise the great toe of the patient. Treating very carefully and sparingly the cicatrix over the end of the bone, and preparing it, he made a transverse section on the dorsal aspect of the great toe at the level of the interphalangeal joint, and to gain space, resected a piece from the basal phalanx, sutured the skin and extensor tendons of the thumb to the corresponding parts of the great toe, and fixed the whole in plaster of Paris, keeping the parts in this position for seventeen days. At first the pain caused by the strained posture was very great, especially in the knee, but it was relieved by morphia. Everything was then well borne, but the heat was much complained of. (This was in July.) At the end of the seventeen days the plantar side of the toe was cut through and fixed to the thumb. The result was excellent. The patient

had a useful movable thumb with which he could grasp and hold firmly.

Herr Stabel showed a young man who twenty-seven days before had undergone whilst at his work very severe pressure over his abdomen. Immediately after subconjunctival hæmorrhage took place, the remains of which were still visible. There were also extravasations of blood under the skin of the forehead, the cheeks, and neck.

Exz. von Bergmann showed a man with

SARCOMA OF THE NOSE.

As much as ten years ago he had had small tumours removed from the nose repeatedly. A big operation, apparently resection of the upper jaw, was done five years ago. The patient had now a large disfiguring tumour on the forehead and base of the nose which forced the eyes apart, and was a sarcoma. Herr Exz. considered it indispensable in retropharyngeal tumours to make the field of operation as open to view as possible, and did not hesitate in such cases to resect both upper jaws, and, beside this, to pull the nose high up, so as to obtain a wide entrance to the nasopharyngeal space.

Herr Gluck had operated on the patient five years before, doing a resection of the upper jaw. The patient was free from recurrence for two years. Then it returned, but he declined further operation until the tumour had reached its present dimensions.

AUSTRIA.

Vienna, Nov. 20th, 1906.

DOUBLE PLASTIC OPERATION TO CRANIUM.

CLAIRMONT showed a patient from Eiselsberg's ward on whom two plastic operations in the cranium were performed at one sitting. A young man, æt. 19, fell from a wall sixteen metres high, on June 6th, and received a complicated fracture of the skull. In hospital two depressed fractured bones were removed. After three days' unconsciousness, paralysis of the right arm, alexia, agraphia paraphasia, and amnesia were observed to be present. Two months later all the soft tissues of the head had healed and the patient was dismissed.

He returned to hospital about the end of September with two defects in the cranium, one in the left parietal bone, the other in the occipital on the left side. Both were covered with soft tissue, depressed and pulsating, arterially and with every respiration. When he stooped he became giddy. At this time there was paresis on the right side of the face, but he was able to spell very well, but read badly.

On September 22, Morphine-chloroform narcosis was effected and an operation commenced to cover both defects with bone, although the patient objected before narcosis to have the bone taken from the tibia. After opening the cicatrices and laying bare the dura mater, the edges of the wound were freshened and a piece of the neighbouring bone with periosteum brought over the wound after Hacker-Durante's method. After fixing with fine catgut the whole was covered with soft tissue. Over this again was placed a perforated celluloid plate to which the soft under-tissue was attached to prevent sinking. There is no pulsation to be seen; the patient can stoop without giddiness, with less paralysis, and more freedom of speech.

LEAD POISONING.

Zappart showed two cases of lead poisoning in girls engaged in handling and finishing French ties. A few years ago he drew attention to the same subject, and found the chronic cases still increasing in number. The silk of these ties is finished with a solution of the sugar of lead, which is dry and dusty when it comes into the workshop for the girls. Their hands, clothes, and hair become impregnated with the poisonous substance, while the air they breathe all day is loaded with poison. This work is often carried to the homes of the workers, where they sleep, eat, and drink, poisoning slowly whole families.

ELECTRIC INJURIES.

Teleky showed photographs from a worker in an electric works, where the current had passed to earth along a bar of iron he held in his hand, injuring the little finger, which the current struck with a force of 110 volts as he accidentally touched the machine. On the back of the little finger there was a wound about the size of a sixpence, at the point of entrance, and another on the inside of the finger one centimetre long and two millimetres in breadth. This confirmed Jellinek's assertion that injuries from electric currents were deeper and more extensive than they appeared, and were therefore longer in healing. The photos of this case, taken eighteen days after the injury, showed the wounds larger than on the day of accident, particularly that on the inside of the finger, *i.e.*, the point of exit of the current.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

BELFAST.

MEDICAL STUDENTS' ASSOCIATION: ADDRESS BY PROFESSOR SCHAFER.—The inaugural meeting of the session of the Belfast Medical Students' Association was held in the Students' Union, Queen's College, on Wednesday, the 14th inst. The President of the Association, Dr. W. J. Leighton, read a paper on "Quacks and Quackery," urging the necessity for Government interference in the matter. Professor Schafer then gave an address on "Resuscitation of the Apparently Dead." He said that his subject was of interest not only from a scientific, but also from a humanitarian and utilitarian point of view. Dealing first with the result of an overdose of chloroform, he said that he knew of no means of resuscitation in such cases, and the best thing to do was to avoid them. He then dealt with the resuscitation of the apparently drowned, and described Dr. Marshall Hall's method, which he called the rolling method, and Dr. Silvester's, or the method of artificial respiration, and Dr. Howard's or the American method. Professor Schafer then gave several tests of artificial respiration by a method which he had demonstrated to be most effective and simple. the prone pressure method. The patient is placed face downwards and pressure is exerted on the lower portion of the ribs, by which air is forced out of the lungs, and when pressure is released there is a corresponding inhalation. The method was explained by lantern diagrams, and illustrated by a subsequent demonstration, and for simplicity and lucidity the whole address was a model for scientific lecturers. On the motion of President Hamilton, seconded by Professor Milroy, and supported by Sir Otto Jaffe, a hearty vote of thanks was accorded to Professor Schafer.

LONDONDERRY CORPORATION AND CONSUMPTION.—The Medical Officer of Health for the city of Derry, Dr. J. H. Fergusson, has started a movement which may have far-reaching results in the North-West of Ireland. In a very full and admirable report presented last week to the corporation, he dealt at length with the prevalence of consumption, and the means to be taken for its suppression. He proposed that a small and influential committee should be appointed to consider the whole matter, and to enter into negotiations with the neighbouring counties with a view to the establishment of sanatoriums. The report is at present under consideration, and it is to be hoped the suggestions in it will be acted upon.

LETTERS TO THE EDITOR.

THE HOSPITAL FOR SICK CHILDREN, GREAT ORMOND STREET.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—My attention has been called to a letter in your issue of November 7th, headed "Great Ormond Street Hospital for Sick Children," and signed "Observer," and I should like with your permission to reply, in order to remove from the mind of your

correspondent one or two misapprehensions, which might possibly find their way into the minds of the readers of his letter.

First, this hospital does not provide for its own neighbourhood only. Considerably less than half of its out-patients are drawn from Holborn, Finsbury, St. Pancras, Islington, and the City, the Boroughs which immediately surround it. The remaining patients, the greater half, if the expression may be allowed —come from all over London and its outskirts, since the central position of the hospital, close to the intersection of High Holborn and Kingsway, allows it to be reached easily and economically from every quarter of greater London. For a tram fare of 2d. a working man's wife and her small child can travel from the remotest point of the East End of London almost to the doors of the hospital. Thus the hospital provides for thosewhom "Observer" considers the "more capable" parents who live outside Central London. But at the same time it must be remembered that many of those inhabiting Central London are not slum-dwellers, as he supposes, but equally capable workmen compelled to live near their work.

Secondly, as to the danger of spread of infection from the congregation of large numbers of children in the out-patient department, special precautions are taken to prevent this. Nurses are stationed close to the entrance of the out-patient doors, who divert into isolation rooms children suffering from infectious diseases or in whose homes there may be infection. Crowded our waiting rooms may sometimes be, but steps are being taken to obviate this by building a new out-patient department which will be finished in about eighteen months' time.

Next, let me say that our chronic cases are already, and have been for the last thirty years, removed to a better atmosphere and healthier surroundings than those of Bloomsbury. We have a branch hospital at Highgate, which holds 30 beds in winter, and 38 in summer. These are filled with chronic cases, for the most part surgical. In addition, two convalescent homes, one in Hampshire and one in Gloucester among the hills, containing eighteen beds between them, are placed by the kindness of friends exclusively at the disposal of the hospital, while the Samaritan Fund helps many more patients to convalescent homes in the country and at the seaside. On the other hand, the air of Bloomsbury is very much healthier than perhaps "Observer" imagines. At the hospital in Great Ormond Street our surgical wards have spacious balconies on which tuberculous cases are able to remain in the open air day and night both winter and summer, with results that it would be difficult to surpass even by treatment in the country or at the seaside.

As regards the ills which arise from bad sanitation and high temperature, there can be no doubt that the most effectual way to combat them is to clear away the unhealthy courts and alleys, where so many London children still have the misfortune to be born and reared, and the hospital views with sympathy all efforts to bring this about. But the process is and must necessarily be a slow one, and in the meantime infective diarrhœa will continue to carry off its annual crop of victims for many summers to come. Consequently it behoves the hospital authorities to do what they can to mitigate the evil, and this they have endeavoured to do by devoting a special ward to these cases, and extra beds in each of the medical wards; some thirty beds in all.

It is true that this is a very small number compared with the number that are carried off every summer week in London by diarrhœa and vomiting, but is it not better to save some lives rather than abandon all to the fate which almost certainly overtakes them if they are allowed to remain in their own homes with only out-patient or dispensary treatment. But over and above this, the devotion of a special ward to these cases enables observations to be made both as to the cause and treatment of the disease which may prove of the greatest value in the future. During the last two years, while the physician in charge of the ward has been investigating the disease from the clinical aspect, the Lister Institute has been carrying on a bacteriological investigation. The results of last year's work in both departments have been published in the medical papers, the results of this year's will be made public in due course, I have no doubt, through the same channels. The students attending the medical school attached to the hospital have already had the advantage of learning them.

I am, Sir, yours truly,

STEWART JOHNSON, Secretary.

November 13th, 1906.

ANTI-VIVISECTION METHODS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—A brief record of the following incident seems worth making. In the *Tribune* of November 8th, there appeared a paragraph headed, "Inspector's Admissions at the Commission." It stated that Mr. Thane, in course of examination, described an operation on a cat by Mr. Starling. "The scalp was skinned off, the skull itself sawn through, and the bone removed, leaving a part of the brain exposed. Electrical needles were driven into the brain, and fixed there by modelling wax. Mr. Starling then thrust a hollow needle through the side of the eyeball into the interior of the eye, and fixed it. The ganglion (*sic*) was then excited by means of the electric needles, and the effect produced on the eye observed and noticed. The cat, Mr. Starling stated, was anæsthetised, but Mr. Thane admitted that it jumped down off the table." On the following day, November 9th, the *Tribune* gave prominence to a statement that their report was untrue, that no such evidence had been given before the Commission, and that they "had been victimised." The grotesque narrative reads like an account of the nightmare of an anti-vivisectionist fanatic, and would have been looked upon with grave suspicion by any one having the slightest knowledge of the methods of experimental physiologists. No doubt the statement has been scattered far and wide among the votaries of the cult; and the lies will not easily be caught up by the withdrawal and the "frank apology" which the *Tribune* makes to the libelled gentlemen whose names it made use of. The *Tribune* is a paper which sets itself up as a pattern in conduct among its contemporaries; this episode is not likely to increase respect for the paper among thoughtful and educated readers.

I am, Sir, yours truly,

PHYSIOLOGIST.

November 17th, 1906.

OBITUARY.

DR. M. O'SULLIVAN, F.R.C.S.

WE regret to record the death of Dr. Michael O'Sullivan, late of 14, Gardiner's Place, Dublin. He qualified in the Royal University in 1892, and became a Fellow of the Royal College of Surgeons, Ireland, in 1900. For twelve years he was intimately connected with the Mater Misericordiæ Hospital, first as resident surgeon, and then as anæsthetist and registrar. For some years previous to his illness he acted as chief physician to the Children's Hospital, Temple Street, but it was to anæsthetics that he devoted a special study. At the time he was seized by an incurable nerve affection, he was commanding an extensive practice.

GENERAL SAMPSON ROCH, R.A.M.C., M.R.C.S.E.

DEPUTY SURGEON-GENERAL SAMPSON ROCH, whose death, at the age of 77, occurred on the 9th inst., at Yougal, Ireland, entered the Army as an assistant surgeon in 1854. He served with the 55th Regiment through the Crimea, including the siege of Sevastopol, and on June 7th accompanied the French in their assault upon the Mamelon. He received the meda

and clasp for the Crimea and Turkish decoration. He retired as a surgeon-general in 1881.

DEPUTY SURGEON-GENERAL J. WILES, M.R.C.S., L.S.A.

WE regret to announce the death of Deputy Surgeon-General Julius Wiles, of De Vere Gardens, Kensington, who was knocked down while cycling on November 10th by a van and died the same afternoon from the injuries he received. The inquest showed that the horses attached to the van had taken fright at a motor-car. Surgeon-General Wiles, who was seventy-eight years of age, had served long and faithfully in the Army Medical Department, which he entered more than fifty years ago.

JOHN GEORGE DOUGLAS KERR, M.B., C.M. GLASG.

WE regret to announce the death of Mr. John George Douglas Kerr, M.B., C.M., on the 14th inst., at Bath. Mr. Kerr at Glasgow University won the double medal in surgery in 1878, and became Master of Surgery two years later. Upon going to Bath he made a special study of the hot mineral waters, to which he published a guide. He was also the author of a number of works associated with thermal treatment. Mr. Kerr held a number of honorary professional appointments, including that of medical referee of the Royal National Hospital for Consumption, Ventnor. He was a magistrate for Somerset, and served for many years as an officer of the North Somerset Yeomanry. Mr. Kerr was an enthusiastic yachtsman, and, with "Valdora," gained, among many other important prizes, the German Emperor's Cup for the Dover to Heligoland race in 1894, and last year the Albert Cup at Southsea

ARTHUR CROSSLEY, M.R.C.S., L.R.C.P.LOND.

THE death took place at Uckfield, Sussex, on the 12th inst., of Mr. Arthur Crossley, son of the late Dr. Crossley, of Leicester, in his forty-fifth year. The deceased gentleman left Leicester about twelve years ago to practise in Eastbourne, and afterwards removed to Uckfield. He was educated professionally at Guy's Hospital, and qualified M.R.C.S. of England in 1880.

JAMES C. RATTRAY, M.D.EDIN.

THE news was received in Swindon last week with genuine regret by a very large circle of acquaintances of the death of Dr. James Carson Rattray, a well-known local medical practitioner. Dr. Rattray had long been a sufferer from an abdominal complaint, but it was hoped that an entire change and absolute rest would restore him to good health. He went to Scotland some few months ago, and died at Aberdeen on Tuesday. Deceased, who was only forty-two years of age, came to Swindon eighteen years ago, and commenced practice. The deceased gentleman was held in high esteem throughout the town and district. He graduated M.B., C.M. of Edinburgh University in 1888 and M.D. in 1889.

SPECIAL ARTICLE.

ROYAL COLLEGE OF SURGEONS OF ENGLAND—ANNUAL MEETING.

AT the Annual Meeting of Fellows and Members of the College on Thursday last (Mr. Henry Morris, President, in the chair), there were present fifty members and twenty-three Fellows. The President placed before the meeting the annual report of the Council, and made a statement regarding the more important matters which had come under the consideration of the Council. He also stated that copies of the Report had been circulated to 684 Fellows and 3,036 Members, who had expressed the wish to have their names entered on the standing list at the college for the Report to be sent to them annually.

Direct Representation.—The question of direct representation of members of the College on the Council has always been to the fore at these annual meetings, and on this occasion Mr. Joseph Smith moved the following resolution, which was seconded by Sir Charles Hutchinson, ex-M.P. for the Rye Division of Sussex, and carried by forty votes to three: "That this twenty-second annual meeting of Fellows and Members again re-affirms the desirability of admitting members to direct representation on the Council, which as now constituted does not represent the whole Corporation."

The Admission of Women.—Dr. W. G. Dickinson then moved the following resolution which was seconded by Mr. J. Brindley James: "That this meeting recommends that, when the question of admitting women to the college examinations is brought before the Fellows and Members, this should be done either by means of a Corporate Meeting or by a poll of the Fellows and Members, inasmuch as the Meetings as hitherto held under the regulations of the Council have no authority to determine any question whatever, and their resolutions on other subjects are almost invariably disregarded by the Council." An amendment was moved to this by Mr. F. G. Parsons and seconded by Mr. A. D. Cowburn, that the words "either" and "or by a poll of the Fellows and Members" be omitted. This was not carried, but, upon the original motion being put to the meeting, another amendment was moved by Dr. A. S. Morton and seconded by Surgeon-Major Ince, that the words "either by means of a Corporate Meeting or" be omitted, and this was carried. The following resolution was thereupon put and carried: "That this meeting recommends that when the question of admitting women to the College examinations is brought before the Fellows and Members, this should be done by means of a poll of the Fellows and Members."

The Midwives Act.—With reference to the Midwives Act, a resolution standing in the name of Dr. A. S. Morton, of which due notice had been given, was not put to the meeting, as the mover accepted the chairman's assurance that the Council was desirous of making representations to the Government urging the necessity of amending the Midwives Act, in order that provision might be made to secure just remuneration for professional services rendered by medical men under that Act.

Preliminary Education.—The following resolution, moved by Mr. George Brown and seconded by Mr. George Jackson, was also slightly altered from that which appeared on the agenda, and was carried by twelve votes to two: "That this meeting strongly urges the Council to use all its influence to secure the raising of the standard of the preliminary examinations in general education and in science, and this meeting is further of opinion that the time has arrived when chemistry, physics, and biology should be treated as matters of preliminary education, and an examination passed in them before the commencement of medical studies."

A vote of thanks to the Chairman for presiding, coupled with congratulations to the ex-president, Sir John Tweedy, on receiving the recent honour of knighthood, terminated the proceedings.

The Kensington General Hospital.

H.R.H. the Princess of Wales has graciously given her patronage, and is showing a kindly interest in the entertainment to be given at the Scala Theatre on the evenings of December 11th, 12th, and 13th, in aid of the Kensington General Hospital, and T.R.H. the Prince and Princess Alexander of Teck have also given their names. This hospital, which has been so completely reorganised and generally reconstructed in every way, both in regard to its Board of Management and its medical and surgical staff, is urgently in need of funds. Few people realise that it is the only hospital in the district, and that nothing in the way of medical attendance for out-patients in this big district can be found nearer than the West London Hospita at Hammersmith, and St. George's Hospital.

MEDICAL NEWS IN BRIEF.

Session of the General Medical Council.

THE Registrar of the General Medical Council requests us to state that the next Session of the Council will open on Tuesday next, November 27th, at 2 o'clock p.m., the President, Dr. Donald MacAlister being in the Chair.

The Irish Medical Association—Special General Meeting.

A VERY largely attended meeting of the Irish Medical Association was held on Wednesday last at the Royal College of Surgeons, to consider the attitude which the Association should adopt towards the report of the Commission on Poor-law Reform, and especially towards that part of it which recommended the institution of a State Medical Service. The meeting was the largest held for many years, and testified to the great interest which the proposed change in the Poor-law Medical Service excited. Unwisely, we think, it was held in private, but, doubtless in a short time all due publicity will be given to its deliberations. In view, however, of the fact that the resolutions were practically unanimously adopted, the Association would have been wiser in giving the result of its deliberations more clearly and explicitly to the press.

The following resolutions were adopted by a very large majority:—

(1) Proposed by Dr. Warnock, seconded by Dr. Thompson, ex-M.P., "That we, the members of the Irish Medical Association, offer our congratulations to the members of the Viceregal Commission on Poor-law Reform in Ireland upon the production of their able report and upon the broad and statesmanlike view that they have taken of the subject, and that the Council of this Association be directed to urge upon the Government the importance of giving effect in the main to the recommendations contained in this report with as little delay as possible; and that in any reform the members of the Poor-law Medical Service and those of the County Infirmary Service should form a homogeneous State service, and be in all respects dealt with in a similar manner."

(2) Proposed by Dr. O'Carroll, seconded by Dr. Singleton Darling, "That this meeting of the Irish Medical Association is strongly of opinion that any body or Council administering the Poor-law Medical Service should contain a majority of members elected periodically from among the members of the profession practising in Ireland."

(3) Proposed by Dr. Magennis, seconded by Dr. Powell, "That all Hospitals and Infirmaries under the contemplated reformed Poor-law Service should be designated by a uniform title."

London Street Noises—Conference of Medical Men.

SIR THEODORE MARTIN, President of the Street Noise Abatement Committee, occupied the chair, on the 12th inst., at a conference of the Medical Society of London to consider the noise problem of the metropolis. He complained that the authorities had been perfectly apathetic in dealing with the question. He described motor omnibuses as "awful machines," and himself as "a victim to the misery inflicted" by them. The Chief Commissioner had made the most extraordinary admission ever made by a public official. He admitted he had the power to stop these Juggernaut cars; but he had not stopped them. The reason he gave was that he wanted an experiment made in the new kind of locomotion. In his (Sir Theodore's) house he could not open a window owing to the stench caused by these vehicles. in bed he was badly shaken; double windows were no protection to him; the ceilings were all cracking. Many of his friends resident in London streets with long leases were being tortured and slowly killed due to the experiment of the Chief Commissioner. The old motto, *Salus populi suprema lex*, no longer had any force.

A resolution was moved by Sir Dyce Duckworth as follows: "This conference of medical men desires to record its conviction that the present excess of noise in the public thoroughfares of London is such as to cause disastrous consequences to the health and vitality of the people, and that legislation in respect to the growing evil of street noises is urgently needed, and should be promoted without delay." He was of opinion that no language could exaggerate the nuisance caused by motor-cars. Their noise and stench were grievously affecting the health of the community.

A second resolution called for legislation to prevent all street shouting, organ-grinding, and street music; for the effective supervision and control as to speed and otherwise of all classes of vehicles; and for the entire prohibition of noisy traffic through purely residential streets at least between midnight and six in the morning.

The resolutions were carried unanimously.

Cork Medical and Surgical Society, Annual Dinner.

THE annual dinner of this Society was held on the 10th inst. under the presidency of Professor C. Y. Pearson, and was most successful. A large number of members and guests were present. After the toast of "The King" had been duly honoured, the president proposed the toast of "The Cork Medical School," coupling with it the names of Professor H. Corby and Dr. J. Cotter. In replying both speakers referred to the successes of Cork students as illustrated by recent achievements. Colonel McNeece, R.A.M.C., replied to the toast of "The Navy and the Army," and in the course of his speech pointed out that the Director-General and the two assistant directors of the Royal Army Medical Corps are Irishmen. Colonel J. Crofts, I.M.S. (retired) also replied.

The Welcome Research Laboratories and Vivisection.

In reply to Mr. G. Greenwood, who asked on the 16th inst. if, as the result of the inquiries promised, he can now say whether vivisectional experiments are habitually performed at Gordon College Khartum, in the Wellcome Research Laboratories, or elsewhere; whether the Gordon College, though not under the control of the Foreign Office, is in any way subject to British control; whether the Wellcome Research Laboratories form part of such college, or what is their connection with it; how such laboratories are maintained, and whether or not by public money; and whether operators in such laboratories or otherwise at the Gordon College are subject to any inspection, regulation, or control, Sir E. Grey says: No vivisectional experiments in the ordinary sense of the term are conducted at the Wellcome Research Laboratories, but from time to time painless hypodermic inoculations have been given to living animals in order to further the diagnosis and cure of the obscure tropical diseases to which men and animals are exposed when living in the Sudan, and many valuable results have been obtained. The Gordon College is under an executive committee and trustees appointed under the Gordon College at Khartum Act, 1899. The research laboratories, the equipment of which was given by Mr. Henry S. Wellcome to the Sudan Government, are affiliated to the Gordon College. The maintenance of these laboratories is a charge upon the Gordon College, the revenue of which is derived partly from an endowment and partly from a grant made annually by the Sudan Government. The laboratories are constantly visited by several members of the Sudan Governor-General's Central Sanitary Board.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS. ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT GYNÆCOLOGICAL AND OBSTETRICAL LITERATURE.

Bladder Affections in Gynæcological Cases.—Grad (*Amer. Jour. of Obst.*, September, 1906). Besides the classical cases of cystitis, the writer calls attention to a form of bladder affection, which, for want of a better term, is named cystitis, and in which many of the subjective and objective symptoms of true cystitis are lacking. In these cases the desire to urinate is intense and very frequent. The patient is tormented night and day with the imperative desire to urinate, and in many cases this is the only subjective symptom present. Palpation does not reveal a tender organ, and the urine is clear and acid in reaction. Epithelial cells and pus are absent. This form of bladder disturbance occurs in the young as well as the old, and is usually due to exposure. Cystoscopic examination reveals an intensely congested tissue, very tender to touch, and the mucous membrane bleeds very readily. The tiny arterioles are intensely congested, and appear to be in danger of rupturing. The temperature is normal, rarely elevated. The treatment of these cases is at times quite problematical, as the therapeutic measures prove very ineffective. The writer has found most success in these rebellious cases from the intravesical instillation of adrenalin chloride, diluting the full strength of the preparation about two-thirds. Though the effect of this on the vesical vessels is only temporary, yet the patient experiences a considerable amount of relief, and after a little initial burning, pain is relieved while the urgency to urination is lessened. F.

Artificial Renal Colic as a Means of Diagnosis.—Hutchins (*Amer. Jour. of Obst. and Gyn.*, September, 1906), continues a report of the investigations in 100 cases of obscure pain in the side, by a method introduced by Howard Kelly. The method consists of the production of an artificial renal colic by forced injections of the renal pelvis. The method of producing an artificial distension of the pelvis of the kidney in order to reproduce or to rule out certain symptoms which may be referable to disease of this organ, consists of catheterising the ureter and passing the eye of the catheter gently up to the pelvis of the kidney; allow patient to rest awhile in a comfortable position, and then inject slowly by means of a glass barrelled syringe of 15 cc. capacity, a solution of methylene blue heated to body temperature. By this means fluid is carefully forced into the pelvis of the kidney until the patient begins to feel pain, and without hesitation states whether this is or is not the same pain as that of which she complains when at home. If the pain is the same then it must be of renal origin; if the pain is definitely not the same, then we can rule out the kidney as a cause, and search for trouble elsewhere. The confusion which is often present between the pain caused by pelvic disease or disease of the vermiform appendix and that of renal origin is shown by a report of 23 cases, in all of which pain was present which might easily have been referred to some trouble situated in the kidney or ureter. F.

Diagnosis of Extra-Uterine Gestation by Rontgen Rays.—Lichtenstein (*Med. Woch.*, March, 1906). The writer considers that an X-ray examination should always be made in cases of abdominal tumour in women where the possibility of advanced extra-uterine gestation cannot be precluded with absolute certainty from the clinical examination alone. In advanced extra-uterine gestation the fœtal parts and the lie of the child are observed on X-ray examination much more plainly than in uterine gestation on account of the thinness of the fœtal sac, the smaller amount of amniotic fluid, and the non-interference of the uterine walls and placenta with the rays. F.

Rupture of the Vagina in Labour.—Hellier, Leeds (*British Medical Journal*, October 6th, 1906), under this heading relates the history of a case. The patient, a 7-para, fell into labour on a Friday afternoon, a midwife being in attendance. During the night and the following morning the labours were said to have been "fairly strong, but not out of the way." At 1 p.m. on Saturday afternoon the pains ceased, and the patient complained of pain in the left hypochondrium. There were, however, no marked symptoms present. The midwife sought the assistance of a doctor, who, at 3.30 p.m., found the head on the perineum, and, applying forceps, easily extracted the child, a full term male. Having delivered, the placenta followed in due course, with no undue hæmorrhage. It was then found that a portion of the omentum was lying in the vagina. This was pushed up. Dr. Hellier was seen in consultation about forty-eight hours after delivery, and found the patient suffering from sepsis of moderate severity. There were no signs of general peritonitis, and the lochia were not excessive or fœtid. On making a vaginal examination, he found a mass of tumefied omentum with a loop of intestine lying above. The hand passed through the vaginal wall. The tear was from the posterior edge of the cervix. The omentum transverse and large, the vaginal wall being torn away and bowels were pushed through the rent, and the vaginal wall sutured to the posterior wall of cervix, and gauze packing introduced on either side of the wound. The condition of the patient became worse, however, and death followed in about twenty-four hours. Having given some statistics and references, Dr. Hellier quotes Freund as to the cause, who holds that in rupture of the uterus there is usually a fixing of the lower uterine segment, as by the cervical wall being nipped between the presenting part and the bone, or by some rigidity or cicatricial condition of the parts, but when the cervix is free to dilate it is the vagina that ruptures under the given conditions, and not the uterus. H.

Nitrite of Amyl in the Treatment of Post-Partum Hæmorrhage. — Keith, Driffield (*British Medical Journal*, Oct. 27th, 1906), reports a case in which he considers the use of this drug was followed by desirable results. The patient was a 4-para, æt. 33, with a history of bad post-partum hæmorrhage after her previous confinement. During her pregnancy she was in a poor state of health, and badly nourished. The labour was normal until after the third stage was completed, when profuse flooding commenced. An inhalation of a capsule of amyl nitrite was administered, and the hæmorrhage was almost immediately arrested. Two pints of saline were given by the rectum, and her pulse, which was 120, soon improved, and in less than one hour was 86. No further trouble followed. H.

Abdominal Hysterectomy for Inversion of the Uterus, Fatty Degeneration of the Inverted Portion.—Barbour, Edinburgh (*Journal of Obstetrics and Gynæcology of the British Empire*, October, 1906).—The author mentions the fact that while changes in the mucous membrane of the inverted uterus have been fully described, he can find no references to changes occurring in the muscular wall. The patient, a 3-para, was admitted to hospital two months subsequent to her confinement, which had been instrumentally terminated, as had her previous two, with all three children stillborn. She

had lost a considerable amount of blood, but the puerperium as far as she felt was uneventful, save that she could not pass her water for the first three days, and it was not drawn off until the third day. The doctor told her then that her "womb was down," but she noticed nothing herself. Six weeks later she was told her "womb was inside out." Still she was in no way troubled, and felt nothing specially wrong. On vaginal examination a mass the size of a golf ball was felt, smooth and round; no cervix was felt. Under anæsthesia the absence of the fundus on bimanual examination, and the inability to pass a sound up alongside the mass, proved the condition. An attempt at reduction was made by fixing the organ and endeavouring to push the fundus up, but this failed. A week later the abdomen was opened, and the posterior rim of the cup-shaped depression was incised through both thicknesses of the uterine wall. Pressure was again exerted from the vagina, and the incision continued posteriorly until the inversion was undone. There was inconsiderable hæmorrhage. The uterus was now seen to be undergoing marked fatty degeneration, so a supra-vaginal amputation of the organ was performed. Microscopically examined, the mucous membrane on the exposed surface of the uterus was entirely absent, its place being taken by a condensed fibrous layer. The muscle fibres underneath this were degenerated; below this, again, there was an area of healthy fibres, and then, nearer the peritoneum, the fibres had undergone fatty degeneration, until immediately below the peritoneum their place was taken by fat. The author advocates the abdominal route as enabling the operator to obtain a better view of the parts, and the condition of the organ after reduction.

H.

The Reaction of Vaginal Secretion.—Investigations which are being made by Bengelsdorff, of Helsingfors (*Archiv. f. Gynäk*, Bd. 78, Hft. 3) concerning the vaginal secretion of pregnant and lying-in women, have suggested also an examination of the vaginal secretion of newly-born infants concerning which investigators differ in important points. The author examined at intervals of twenty-four hours the secretion of vulva and vagina obtained by means of a Pasteur's pipette fitted with an aspirator. The tables which he gives concerning twenty cases show that the vaginal secretion of the child immediately after birth may be alkaline, neutral, or more rarely acid. After a few hours or days it becomes altered, and is always acid. Bacteria take no part in this change, because it occurred in cases in which no bacteria could be found. In two cases in which the opening in the hymen was very small, closely surrounded by the labia minora, and covered over with vernix caseosa, the reaction immediately after birth was acid. The author concludes, therefore, that the vaginal secretion generated in utero is acid, and only becomes neutral or alkaline from entrance of the acid liquor amnii by diffusion or the movements of the child. When bacteria were found they were most usually the bacillus coli and the staphylococcus albus. Döderlein's vaginal bacillus could not be found by the author immediately after birth in any of the cases. It does not appear, therefore, to take any part in the production of the acidity during the first days of life.

G.

The Effect of Rontgen Rays on the Ovaries.—The microscopical appearance of the ovaries of rabbits after they have been subjected to the Röntgen rays is described by Specht (*Archiv f. Gynäk*, Bd. 78, Hft. 3). As Halberstädter has already demonstrated, a complete disappearance of the Graffian follicles occurs in the majority of cases, and the primary follicles, much diminished in number, showed distinct signs of degeneration. In addition, Specht observed that in the greater part of the interstitial substance of the ovary the cells were much smaller and much poorer in protoplasm on the rayed side than on the other. Through this discovery, the diminution in size of the ovary which has been rayed in comparison with the other may be completely explained. In order to recognise the very first signs of degeneration, the author, at different intervals, removed ovaries which had been subjected to the rays for one to two hours. At periods varying from 12 to 24 hours alterations were already to be found in the primary follicles and interstitial tissue, which were in all probability due to the action of the rays. If a method should be discovered by which the sensitive human skin could be protected from injury by the rays, the latter might take the place of some operative measures now in use.

G.

Chronic Oophoritis and the Physiological Variations in the Structure of the Normal Ovary.—Theilhaber and Meier (*Archiv f. Gynäk*, Bd. 78, Hft. 3) hold that the clinical symptoms, tenderness, size, consistence, shape, etc., do not prove the presence of chronic oophoritis. Theilhaber also considers that the usual anatomical conditions given in the literature, thickened albuginea hyperplasia of the connective tissue, diminution of the follicles, alterations in the walls of the blood-vessels, are not at all pathognomonic. The ovaries of 86 women, 69 of whom had no gynæcological disease, were examined by Meier. The results of his difficult and extremely interesting investigations demonstrate very great variations, physiologically, in the structure of the normal ovary, among them being diffuse thickenings of the albuginea, increasing diminution in the number of Graffian follicles as age advances, hypertrophy of the connective tissue, and alterations in the walls of the blood vessels. Arteriosclerosis is not characteristic of chronic oophoritis, neither is hyaline degeneration of the vessel walls. Accumulations of large numbers of small round cells are frequently found in the neighbourhood of not too old corpora lutea. True oophoritis only exists in connection with salpingitis. In these cases one frequently finds thick scar-like bands of connective tissue crowding deeply into the parenchyma and completely taking its place. Cystic degeneration is also found. Theilhaber does not believe that idiopathic chronic oophoritis exists. In those cases in which it is diagnosed on account of localised tenderness, one is generally either dealing with the neurosis which may coincidently be combined with the presence of an unusually large ovary, or we have the remains of a salpingo-oophoritis.

G.

Puerperal Infection.—Hellendahl, Tübingen (*Beiträge zur Geb. und Gyn*, Bd. 10, Hft. 2) considers in this the second part of his investigations the effect of infected liquor amnii on the mother and child. He established by experiment that penetration of the intact membranes by virulent bacteria is quite possible. They extend upwards between the uterine wall and membranes, and force themselves through the membranes into the liquor amnii. They may also extend from the peritoneum through the tubes. Infection of the liquor amnii extending from the blood-vessels of the uterine wall only plays a subordinate part in comparison to the infection extending through the placenta. The latter is a most important path of infection. The fœtus may be infected from sucking in the liquor amnii owing to premature attempts to breathe, or from spontaneous entrance of the bacteria into the body openings. In cases of general infection of the fœtus, it usually has its primary focus in the lungs. Owing to intra-amniotic infection the fœtus may die in utero or post partum. The latter is caused either by a pure bacterial broncho-pneumonia or by general sepsis associated with broncho-pneumonia. A general infection extending from the intestinal tract is also possible. For the mother the most important cause of fever intra partum is premature rupture of the membranes; but it may also arise when the membranes are intact. A prognosis regarding the puerperium cannot be made from the height of the fever during parturition.

G.

Irish Medical Schools and Graduates Association.

THE autumn dinner of the Irish Medical Schools' and Graduates' Association will take place at the Hotel Great Central, Marylebone Road, London, N.W., on Wednesday, November 28th, at 7.30 p.m. The guest of the Association will be Admiral Sir Edward Seymour, G.C.B., O.M. Tickets can be obtained by members of the Association from Mr. E. Canny Ryall, 85 Harley Street, W.

NOTICES TO CORRESPONDENTS, &c.

☞ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to 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 proofs.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions, the same rule applies as to office; these should be addressed to the Publisher.

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.

SUBSCRIPTIONS.

SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance.

R. S. (Ipswich).—A good alkaline tooth-powder is :—

Pulv. Iridis	- -	dr. s.
Ol. Cinnamomi	- -	m. iij
Mag. Carb. Pond.	- }	aa dr. iv.
Cretæ Precip.	- }	
Misce.		

A. S. T.—The idea that flies take part in the propagation of disease is not as new as you, and probably many others, think. Ambroise Paré mentions as his opinion that flies certainly tend to disseminate plague. Vide Œuvres Complètes, 1575. Book X., Chap. VI.

DR. P.—The earliest observations in this country were, we believe, those of Schäfer and Oliver. But there have been many published observations on the physiological action of suprarenal glands since.

PLEXUS.—Your informant is right. We do not greatly admire the new phraseology, but the word autosite is regularly used to denote a monstrosity capable of independent existence.

DESMOND.—The patient clearly belongs to A, but if he wishes to change there is no ethical reason why he should not go to you.

TWEED.—We are interested to hear that the St. Andrew's Ambulance Association is now working in England. Mr. L. Darlington, of 5 Kirkgate, Bradford, is the honorary secretary of the Bradford centre. If that town is in your neighbourhood, you had better apply to him.

L. D. (Bradford).—Thank you for your letter. Please see answer to Tweed.

THE TENURE OF POST-OFFICE SURGEONCIES.

A CORRESPONDENT writes to ask the date on which the age limit of Post-office Surgeoncies was brought before the attention of the House of Commons. At the moment of going to press we have not the exact reference to hand, but it can be readily found by looking through a list of questions asked in the House during the ten days or so prior to our issue of the 14th of November.

NURSE W. H. H.—We are obliged for your letter, and for the facts you bring to our notice. There is no doubt, we believe, that there was a general and most unfortunate misunderstanding. There should be no prejudice now that all is made clear.

STAMFORD.—The death-rates for the three towns mentioned are :—21·4, 46·3, and 51·8 per 1,000 respectively. The plague naturally accounts for much.

MEDICO.—The recent Order *re* certificates of instruction in vaccination was issued on December 20th, 1905. It applies to medical men qualified on or after May 1st, 1906, and to them only.

G. P. (Wells).—Arterio-sclerosis most commonly occurs in elderly persons of the male sex, who have had syphilis or who have indulged in alcohol to excess.

RESPICE FINEM.—The fees for medical evidence in the High Court vary. Of course if a witness, being a medical man, gives evidence as an ordinary, and not as a professional witness, he cannot claim more than the ordinary witnesses are paid. On the other hand, the fees of experts are generally a matter of arrangement with the solicitors and parties by whom they are summoned.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, NOVEMBER 21st.

ROYAL MICROSCOPICAL SOCIETY (20 Hanover Square, W.).—8 p.m.: Paper :—Mr. J. W. Gordon: The Use of a Top Stop for Developing Latent Powers of the Microscope.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. M. White: Clinique. (Surgical.) 5.15 p.m.: Lecture :—Dr. A. Morison: Disorders of Cardiac Motion, their Nature and Treatment.

LONDON SCHOOL OF CLINICAL MEDICINE (Dreadnought Hospital, Greenwich).—2.30 p.m.: Operations. 2.30 p.m.: Dr. F. Taylor: Medicine. 3.15 p.m.: Mr. M. Robson: Surgery. 4 p.m.: Mr. Cargill: Ophthalmology. Out-patient Demonstration :—10 a.m. Surgical and Medical. 11 a.m.: Eye.

THURSDAY, NOVEMBER 22nd.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture :—Dr. A. Morison: Disorders of Cardiac Motion, their Nature and Treatment.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m.: Chesterfield Lecture :—Dr. M. Dockrell: Acne Vulgaris in its Three Stages: I., Comedo; II., Indurata III., Necrotica.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Mount Vernon Hospital, Hampstead).—5 p.m.: Demonstration: Dr. J. E. Squire: Cases of Chest Disease.

FRIDAY, NOVEMBER 23rd.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8.30 p.m.: Special General Meeting *re* Amalgamation of Medical Societies. Papers :—Dr. J. W. Carr: A Case of Hæmorrhage into the Frontal Lobes of the Brain.—Dr. J. Fawcett: Acute Peritonitis with Fat Necrosis apart from Disease of the Pancreas. Mr. W. G. Spencer: Cystic Dilatation of the Lower End of the Ureter, containing Calculi which became engaged Intermittently in the Urethra.

BRITISH ELECTROTHERAPEUTIC SOCIETY (11 Chandos Street, Cavendish Square, W.).—8 p.m. Council. 8.30 p.m. Discussion on the Report of the Organising Committee for the Union of Medical Societies of London (opened by Dr. H. L. Jones). Paper :—Dr. G. H. Graham: Notes of an Unusual Fracture of the Fifth Metatarsal Bone (illustrated by a radiograph). Demonstration :—Dr. D. Baynes: New Form of Electrical Apparatus.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.:—Mr. M. Yearsley. Clinique. (Throat.)

Vacancies.

Aberystwyth Infirmary and Cardiganshire General Hospital.—House Surgeon and Secretary. Salary £150 per annum, with board and residence. Applications to R. T. Edwards.

Bethlem Hospital. Two Resident House Physicians. Salary £25 each per quarter. Applications to the Treasurer, Bridewell Hospital, New Bridge Street, E.C. (See advt.)

Newcastle-on-Tyne Union.—Assistant Medical Officer. Salary £150 per annum, with furnished apartments, rations, and washing. Applications to James Atkinson, Clerk to the Guardians, Union Offices, Pilgrim Street, Newcastle-on-Tyne.

Brentford Union.—Assistant Medical Superintendent. Salary £120 per annum, with furnished apartments in the Infirmary, rations, and washing, &c. Applications to William Stephens, Clerk to the Guardians, Union Offices, Isleworth.

West Riding Asylum, Wadsley, near Sheffield.—Fifth Assistant Medical Officer. Salary £140 per annum. Applications to the Medical Superintendent.

St. Mary's Hospital, Paddington, W.—Resident Casualty House Surgeon. Salary £100 per annum, with board and lodging. Applications to Thomas Ryan, Secretary.

Bristol General Hospital.—Senior House Surgeon. Salary £150 per annum, with board, residence, &c. Applications to the Secretary.

Durham County Council.—Inspector of Midwives and Health Visitor.—Salary £120 per annum, with travelling expenses. Applications to T. Eustace Hill, County Medical Officer of Health, Shire Hall Durham.

Northampton.—Saint Andrew's Hospital for Mental Diseases.—Third Assistant Medical Officer. Salary £150 per annum, with board, lodging, and washing. Applications to the Medical Superintendent.

Appointments.

COX, A., L.R.C.P. and S.Edin., L.F.P.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Gateshead District of the county of Durham.

CRAFTON, W. M., M.B., B.S.R.U.I., Certifying Surgeon under the Factory and Workshop Act for the Sutton Bridge District of the county of Lincoln.

DRINKWATER, R., L.R.C.P. and S.Edin., L.F.P.S.Glasg., Medical Officer of Health by the Llangollen Rural District Council.

HUNTER, D. G., M.B., Ch.B.Glasg., House Surgeon to the Durham County Hospital.

JOYNES, FRANCIS JAMES, M.R.C.S., L.S.A., Medical Officer of Health for the Dursley (Gloucestershire) Rural District Council.

LAING, A. W., M.B., Ch.B.Aberd., House Surgeon to the Birmingham and Midland Ear and Throat Hospital.

Births.

CHARNOCK SMITH.—On Nov. 17th, at Steyning, Sussex, the wife of C. Charnock Smith, M.R.C.S., &c., of a daughter.

MANSELL.—On Nov. 12th, at 278 Portland Road, Woodside South Norwood, the wife of A. R. Mansell, L.R.C.P., &c., of a daughter.

Marriages.

BURTON—LEAF.—On Nov. 15th, at Immanuel Church, Streatham Common, Arthur Burton, M.D., of Cromer, the youngest son of the late Edward Frederick Burton, of 15 Cleveland Gardens, London, to Olive Clare Leaf, the youngest daughter of the late Frederick H. Leaf, of Streatham Common.

MARSHALL—COOKE.—On Nov. 14th, at Aldridge Parish Church, Alfred Turner Marshall, B.A., son of the late Rev. Alfred Marshall and Mrs. Marshall (Wigston), to Matilda Rachel Cooke, youngest daughter of the late William Harry Cooke, M.D., and Mrs. Cooke, Aldridge.

SANDERSON-WELLS—LAWRIE.—On Nov. 14th, at St. John's Church, Weymouth, Thomas Henry Sanderson-Wells, M.D.Lond., eldest son of John Septimus Wells, of Banbury, to Agnes Macpherson (Nan), eldest daughter of Dr. James Macpherson Lawrie J.P. D.L., of Greenhill, Weymouth.

Deaths.

MARRACK.—On Nov. 15th, at Caer-Eden House, Lyonsdown, New Barnet, Jessie, wife of Richard Marrack, of Lincoln's Inn, barrister-at-law, and daughter of the late John Gregory Forbes, F.R.C.S., aged 56.

NORTON.—On Nov. 17, at 63 Upper Gloucester Place, London, George Everitt Norton, M.R.C.S.

SANKEY.—On Nov. 16th, at Boreatton Park, Baschurch, Salop, Mary Ann, widow of W. H. O. Sankey, M.D., F.R.C.P., aged 86.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIII. WEDNESDAY, NOVEMBER 28, 1906. No. 22

NOTES AND COMMENTS.

Professional Differences.

ONE hears *ad nauseam* of doctors differing; indeed, the cant phrase embodying the idea always makes an effective hit when suggested by a barrister in difficulties, or a journalist in search of an argument. But such is the majesty of law that the conflicting opinions of judges are looked upon as inevitable sequelæ to high legal learning, and instead of each of the disputants being written down as a fool, he is regarded as either a Titan or an Olympian. Far be it from us to detract from the dignity of the Bench, but we may say that our own respect for it has not been distinctly enhanced by reading some remarks of Deputy-Judge Layman at the Southwark County Court, with regard to an application for a new trial made to him in the case of Hathaway *v.* Peers earlier in the month. The plaintiff in the suit had complained of negligent treatment in her confinement, and in spite of the expert testimony of a well-known obstetrician, who said that the case had been skilfully conducted, the jury had awarded her £25 damages.

Judge versus Jury.

IT was known, however, that the jury were divided in opinion, and the defendant by his counsel subsequently appealed for a new trial. Deputy-Judge Layman, nevertheless, said that he could not grant one, as the issue had been presented to the jury and decided by them, and he could not see how it was possible to say that it was so unreasonable that he could set it aside. But in justice to the defendant, he added that he might say that if he himself had had to determine the matter, he would unquestionably have found for him. Here is a clear case in which a lawyer trained in the sorting and weighing of evidence finds "unquestionably" that the verdict was against the evidence, and therefore by a natural process of reasoning grossly unjust; yet he is unable to grant a new trial. The plain man can only conclude that a process of law so defective merits the contempt of the community.

The Sublime Port.

AN epidemic of scarlet fever lately took place on the "Arethusa," a training ship moored in the Thames where lads are prepared for the mercantile marine. Of the two hundred boys on the ship, no less than fifty-one caught the disease, and one died. Dr. Hubert Williams, medical officer to the Port of London, in reporting to his Authority, said that it early became obvious that if the outbreak were to be stayed, a large number of the lads should be treated as contacts, but that means of isolation were practically non-existent, because the available hospital accommodation was soon used up by those already sick. Now this question of providing adequate accommodation has, it appears, several times been before the Port Sanitary Committee, but that body in its wisdom does not think it "reasonable" that it should be called on to do so. And why not, indeed? The purpose for which sanitary authorities are armed with powers is that they may use them for the benefit of those whom they govern, and though it may be most unreasonable for epidemics to break out, it is a way epidemics have. The reasonableness of the Port Sanitary Authority would be a little sweeter if it realised its full responsibilities.

Consumptive Boycott.

BUT reasonableness is a hard quality to cultivate. In a recent issue of the *Daily Graphic* was recorded an interview with the honorary secretary of the National Association for the Prevention of Tuberculosis, in which that gentleman deplored the fact that it is difficult for a "cured" consumptive to get employment. "Their fellow-workers object to them, fearing infection—without any ground, of course, because even if not entirely cured, the patients have been taught to exercise every precaution. It is a great pity this, and very sad." The fact is indisputable, but as the National Association for the Prevention of Tuberculosis is the body which, more than any other agency, taught people that consumption is infectious, it is not without humour that the secretary should complain that people have learned the lesson too well. The real lesson, it seems to us, is that owing to the natural density of the human brain, societies in a hurry are apt to do almost as much harm as good.

Lombroso Spiritualised.

THE Spiritualists deserve felicitation on their latest convert. Professor Lombroso is a man who bears a great name, and though his enthusiasm is not always well directed it has carried him through many difficulties to a high position in the scientific world. He lately wrote an article in *La Lettura* relating his favourable impressions of a spiritualistic *séance*, and though a scientist has replied in another journal stating that the phenomena observed were

produced by trickery, the great criminologist has replied with conviction that he adheres to his beliefs. After relating the various tests he applied, such as surrounding the mediums with an electric net provided with bells which would ring on the least movement, Lombroso asks what further proof could be required. We should say that the evidence that would convert a hard-headed man with the acuity of a Huxley, and the technical knowledge of a Maskelyne, would be good enough for anybody, but that Spiritualism has more worlds to conquer than that inhabited by the genial, soft-hearted enthusiast which it has just captured. In this country, at any rate, we have heard considerably less of the Spiritual impostures of late years.

LEADING ARTICLES.

SOCIALISM AND MEDICINE.

The process of "intelligent anticipation" is one which has a great fascination for all people, from Mr. H. G. Wells to the least imaginative policeman that paces his measured beat, and as long as a forecast is based on reasonable probability it is not without utility. Now the prophets of the day were all set agog by the result of the election at the beginning of the year especially by the return to Parliament of a band of Labour members, and from speculations on the effect of Protectionist measures on the country they have now turned their minds to the prospects of Socialism. If we read them aright they see in the not far distant future the complete triumph of collectivist principles, with national land and national labourers, national railways and national engine-drivers, national mines and national miners. Well, that may be so, and we should only join the ranks of the prophets if we expressed the opinion that it would not. Two great arguments stand in the way: first, that such a change would be a triumph of rationalism, and if rationalism turned out such a dismal fiasco in France, its chances in England must be less than nil; and secondly, that the person who imagines the free-born Briton is going to be municipalised into an automaton must read history strangely. But without straying into purely political issues it may with some confidence be predicted that the rôle of the State in communal life is likely to follow yet further the course it has steadily been taking for the last fifty years, namely, that of assuming larger responsibilities towards the individual than the old-fashioned Radical would have contentedly allowed. It is almost startling to recall the fact that Bright and Cobden and their followers were bitterly opposed to the Factory Acts, measures whose beneficence is gratefully acknowledged by men of all shades of opinion to-day. The Factory Acts, however, were only an early instalment of a number of Acts of repressive tendency of which the compulsory Vaccination Acts, the several Public Health Acts and their amending Acts, the Food and Drugs Act, and a dozen such, are notable examples. If, then, this process of care for the individual is to develop at the rate it has been developing of late years, is it within the horizon of practical politics that doctors themselves as guardians of the individual health and welfare will be co-opted by the State? We are moved to these thoughts by the odd coincidence that lately, side by side with the report of the Poor-Law Commissioners for Ireland recommending the institution of a State Medical Service, there appeared in the *Labour Leader* an article sketching out the lines of a Socialistic Medical Service. The writer in that journal, himself a medical man, proposed that the country should be mapped out in medical parishes on the lines of ecclesiastical parishes, and that to each 8,000 rural inhabitants or 10,000 urban ones three medical practitioners should be appointed for attendance in illness. Each district should be in touch with a centre where not only would a hospital be available for serious cases, but also a specialist staff, any member of which the local doctor could summon for consultation when desired. On the plan proposed every general practitioner would carry the stethoscope of a consultant in his top-hat, so to speak, and if he showed a tendency to specialise he would be granted study facilities for the purpose he had in view. An interesting part of the scheme is that at each centre there would be well-equipped laboratories for research purposes, staffed by men who had shown aptitude for the work. Moreover, every practitioner should have a course of four weeks' post-graduate study every year at a hospital centre to keep himself abreast with the advance of his profession. The whole service should be based on competitive examination, and promotion likewise should be determined by that test. At first sight this scheme seems inviting enough, but how far, it may well be wondered, would it be a remedy for present discontents between the profession and the public? A State Medical Service for the poor in Ireland has long passed beyond the stage of being a desideratum; it is a crying necessity, and unless the recommendations of the Commission under that head be put into practice, it is difficult to see how the guardians are to obtain skilled medical aid for their paupers. But it is a far cry from a State Service for State protégés to making the public with its own money in its pocket employ the doctor detailed to their district whether they like him or not. The public want a doctor whom they like, know, and trust, and medical men want patients who have confidence in them. These ends are attained by free competition and not by Government regulations. Moreover, the very name "medical research" stinks in the nostrils of the Socialistic party, and it may be taken for granted that no laboratories, and consequently no scientific advance, would be sanctioned under their régime. Finally, one would soon find all the grievances of contract practice blazing out with redoubled energy, and on reflection we think it better to bear the ills we have than to fly to others that we know not of.

PHYSICAL DIAGNOSIS.

THE medical art is eminently scientific, inasmuch as it is founded on reasoned methods of investigation. Every advance is the result of the discovery of fresh facts, either by greater accuracy of observation or by the inclusion of novel machinery in the shape of some newly-born ancillary science. Take, for instance, bacteriology. The merely curious and interesting researches and speculations of Pasteur in one generation have in another simply revolutionised the whole attitude of mankind towards disease as one small portion of his environment. In a less degree radiography may be cited as a second example. The accurate investigations of Sir William Crookes into the phenomena of electrical discharges in high vacuum have led to such important things as wireless telegraphy and the art of Röntgen-ray diagnosis. The latter method adds greatly to the resources of the physician, and still more to those of the surgeon by enabling him to investigate many physical conditions hitherto wholly or partly inaccessible. Indeed, physical diagnosis may be described as the revealing of objective symptoms by special methods of investigation. The development of this branch of semeiology was admirably sketched by the illustrious French physician, Professor Potain, in an article published in the issue of THE MEDICAL PRESS AND CIRCULAR of November 7th. He pointed out that our forefathers in the art knew practically nothing of physical semeiology, which occupied an insignificant place in the art of the physician who was not capable of elucidating them. The modern observer, however, is in possession of a great variety of methods of exploration, and the study of physical signs has accordingly acquired an immense and extended importance. One of the essential foundations of his work has been a knowledge of the main facts of pathological anatomy. The absence of that information among the ancients, owing to the fact that dissection of the dead was not permitted, may account for their non-discovery of auscultation and percussion. As Professor Potain remarks, it is no exaggeration that Laennec founded a new science, which he practically created in the space of two years at the beginning of the nineteenth century. The hundred years that have elapsed since the introduction of the stethoscope mark but a short period in the progress of medical science. In spite of much that has been achieved, a great deal remains to be accomplished before physical diagnosis can be regarded as nearly approaching the level of an exact science. That proposition, indeed, requires to be at once qualified by the addition of the limitation of the method to accessible organs, for it is hardly possible to imagine routine methods of ascertaining the intimate objective conditions of such inaccessible regions as the brain and spinal cord. But even in well-recognised and readily accessible positions the most experienced physician is liable at times to go astray. In such cases the usual physical signs may be non-recognisable or misleading. Professor Potain, in the article above-mentioned, discusses these insidious cases under the term "latent diseases." As an illustration he mentions a patient who was under his care in 1894 for rheumatic endocarditis, which left apparently only a slight affection of the mitral valve. Ten years later she was admitted with pronounced cardiac hypertrophy, which could not be explained by so slight a mitral lesion. The patient died of heart failure, and *post mortem* the explanation was found in the shape of an extensive obliterating pericarditis, which had determined the cardiac dilatation, but which had escaped detection during life. Among the latent diseases that most readily escape our observation, the writer cites cerebral tumours, cancer of the kidney, cardiac symphysis, ulcer of the stomach, and renal calculus. It is interesting to reflect, however, how much light can be thrown upon these particular conditions by the ophthalmoscope, the microscope, chemical analysis, exploratory incision and radiography respectively. There are still many obscurities in physiology and pathology, the clearing up of which may at any moment put us in possession of new or improved means of physical exploration. Electricity, for instance, offers a well-nigh inexhaustible set of problems. At the same time it may be pretty confidently assumed that the cultivation of the clinical faculty will always be an essential of first importance to the success of the physician.

NOTES ON CURRENT TOPICS.

A University for Munster.

THE generous offer recently made by Mr. William O'Brien, M.P., to leave his entire fortune as a contribution to endow a university for the province of Munster has added a new interest to the proceedings of the Royal Commission on Trinity College, Dublin, and also has caused considerable surmise as to the attitude which will be adopted by the Roman Catholic hierarchy towards Mr. O'Brien's scheme. It is obvious that if the latter means anything it means the establishment of a "mixed" university, and as the hierarchy have explicitly declared against any such institution it is difficult to see how they can support Mr. O'Brien's scheme. Mr. O'Brien made his most generous offer at a public meeting held in Cork, and he further said that he would immediately provide the sum of £50,000, if the Borough Council and County Councils of the province were willing to assume a small temporary burden. This would provide an income of £10,000 a year for five years, and if to it was added the present endowment of £10,000 a year and the private benefactions which would undoubtedly be given by Cork citizens, there would be sufficient to enable a start to be made without appealing to the State for a farthing. Mr. O'Brien was further of opinion that the scheme of

the president of the Queen's College for altering the constitution of the College had the consent of many members of the Cabinet. Several resolutions were passed by the meeting approving of Mr. O'Brien's proposals, and recording the opinion that a separate and independent university should be created for Munster, with its seat in Cork.

Medical Men and the Public.

Signs are not wanting that the public is beginning to recognise that, taking it all round, the medical profession is overworked and underpaid. The man in the street, however, is not likely to permit so faithful and indispensable a friend to fall by the wayside without making an effort at rescue. He knows that the happiness of himself and his fellows depends on medicine more than all the professions, learned and unlearned, put together. So that it is to be hoped he will look carefully into the grievances of the medical practitioner, and see if nothing can be done to control the hospitals and the horde of quacks and of other competitors who take the bread out of his mouth. At the same time medical men must keep their powder dry as well as put their trust in God. They will have to insist upon getting a really representative General Medical Council, as a first step towards advancing Medical Acts for the protection of the public against fraudulent quackery. In Prague medical men have struck against Sunday work, and have agreed not to see any patients between Sunday mid-day and 8 o'clock in the evening. Certain medical men are told off to attend urgent cases, and their names and addresses are duly published. This step is one of obvious prudence on the part of a profession that is subject to the most arduous and exacting toil both by day and by night. Why should not a similar common-sense rule be adopted by medical practitioners in the United Kingdom?

Aberdeen and School Ophthalmia.

For many months past an epidemic of epidemic conjunctivitis has been raging amongst the school children of Aberdeen. On the 16th November no less than 21 new and 66 old cases were treated at the Aberdeen Eye Institution. Naturally it would be imagined that the school authorities would have taken immediate and stringent steps to stamp out the malady. The surgeon to the Institution, Dr. Galloway, however, has written to the *Aberdeen Journal* a letter that reveals an extraordinary attitude on the part of the School Board, which appears to be absolutely indifferent to the serious issues involved. Since the 1st of January of the present year 1,048 cases have been treated at the Institution, and doubtless many have been under medical men elsewhere. Dr. Galloway states that under his care is a recent case of a child of nine years, whose mother received a note from a headmaster of a board school saying that unless the child were sent to school at once a prosecution would follow. A similar communication reached the parents of a little girl who that very morning arrived at the Institution "with her eyes glued up with discharge." The sooner the School Board of Aberdeen infuses a leaven of common-sense into the administration of affairs the better for its citizens. Surely in face of such an epidemic every public school, if not at once closed, should be submitted to rigorous skilled medical inspection from day to day.

Medical Men and Fees for Medical Attendance.

Of all the honourable customs that dignify and grace the medical profession perhaps the most scrupulously cherished is that which forbids a medical man to accept fees from a brother in his own profession. Indeed, so far is the principle extended that in many cases the children of a medical man are also exempted, even when they are established in other walks of life, and their father has long since been dead. In a recent King's Bench action for damages, however, the plaintiff, a medical practitioner from Kingston, made some extraordinary statements upon this point. He had been injured as the result of a trap accident, and had received a bill from a local doctor, who had attended him, for £24 15s. In answer to a remark from the Judge, counsel for the plaintiff said that it was by no means an uncommon rule now for a medical man attending another medical man to charge for his services. We beg to differ absolutely from the gross perversion of facts conveyed in that assertion. Now and then a well-to-do medical man may press a fee, directly or indirectly, on a less prosperous brother professional, but that there is any general custom of charging fees for such services is untrue. It is not easy to imagine how that curious belief could have suggested itself to learned counsel, unless, indeed, the account was introduced by the solicitors for the sake of swelling the claim for damages. But why, in that case, bolster it up with so mendacious an assertion?

The Proposal for a State Medical Service in Ireland.

THE proposal for a State Medical Service in Ireland put forward by the Viceregal Commissioners on Poor-law Reform, contains a condition to which, on general grounds, we think serious objection should be offered. It is that "the proposed Irish Medical State Service should, at all events for the present, be restricted to candidates educated in Ireland." We doubt whether it would be possible to induce Parliament to grant public money for a Service restricted in such a way, but, apart from this, the proposal itself opens very unpleasant prospects. We have long struggled against the iniquitous system under which certain hospital appointments in England are closed against Irish and Scottish candidates, and such appointments are becoming fewer every year. What is to be thought, then, of the suggestion that the public medical service of a whole country should be limited to candidates from three or

four schools? If a State Service is to be founded for Ireland, it should be as free and open to all comers as the other Government services. The practical difference may be slight, as it is unlikely in any case that many English or Scottish candidates will be attracted. It is, perhaps, somewhat early to discuss the details of the scheme, but the point of principle raised seems to us important.

Mr. Birrell and the Teaching of Hygiene.

The answer given by Mr. Birrell to the deputation which waited on him last week in reference to the teaching of hygiene in primary schools, while courteous and even sympathetic, hardly went as far as one would have hoped. Doubtless some of the members of the deputation were in part responsible for the undecided character of the interview, since they did not content themselves with pressing forward the special objects they had in view, but dragged in altogether extraneous subjects. The special points put forward in the memorandum presented to Mr. Birrell were three—the teaching of hygiene and temperance in the primary schools, the training of teachers in these subjects, and the reporting on them by the Inspectors of Schools. Not content with this fairly suggestive text, one at least of the deputation seized the opportunity to discuss the quite different subject of medical inspection of schools. With regard to the first of the three points raised, Mr. Birrell seemed to think that there would be some difficulty in arriving at any body of doctrine suitable for the instruction of the young, on which men of science would be in agreement. This, however, does not present any formidable obstacle, for though there are differences of detail between individual thinkers, yet the elemental principles of hygiene and temperance receive the assent of all. With regard to the other points, the Minister of Education was a little more encouraging, taking care, however, to emphasise the importance of hurrying slowly.

Herbalism Generously Disposed.

The Privy Council grinds slowly, but in the case of the herbalists' charter, of which we spoke last summer, it has ground exceeding small. In fact, it has had the good sense to grind the idea of a charter out of existence altogether. It was, indeed, hardly conceivable that any responsible body would entertain such a farcical notion for a moment, even though the three recognised colleges in the United States offered free scholarships to students from England who would go to them for "training" for the professoriate. But, nothing dismayed, the herbalists have apparently turned their attention to cancer research, and great deeds are about to come forth. To encourage this beneficent movement, a Mr. W. H. Webb—we are not sure if he is "professor," but perhaps he will pardon our ignorance of his style—is prepared to grant the use of his sanatorium in Lancashire for two years, free of rent and rates, to a committee of enquiry. If their report is favourable, he will hand the sanatorium over to a "Board of Education" to be composed partly of members of the People's League of Medical Freedom, and partly of those of other equally important bodies at half price. This offer seems rather an unpromising way of getting rid of the sanatorium if it is a white elephant, and rather a grotesque one if it does so much good under its present *regime*. Men have been known to give up much for their faith, but a sanatorium at half-price strikes us as unparalleled generosity.

PERSONAL.

The Empress of Germany has signified her gracious consent to be a patroness of the Fourteenth International Congress of Hygiene and Demography, which is to take place in Berlin in September, 1907.

Dr. Colston Wintle was re-elected chairman of the Bristol Health Committee on November 20th.

Dr. F. W. Bennett has been elected secretary of the Section of Geology, and Dr. Allan Warner secretary of the Section of Physiology for the British Association meeting in Leicester next year.

Professor Bernherd Fraenkel, the veteran laryngologist, received a large number of presents and addresses on attaining his seventieth birthday last week. Sir Felix Semon personally took him an illuminated address from the Laryngological Society of London.

Dr. Hebert, on whom a murderous attack was made in France last week, is a Canadian graduate, who, after qualifying in England, settled down in London. Dr. Hebert now lies at the Lariboisière Hospital, shot in the forehead and the jaw.

At the fifth meeting of the Royal Commission on Vivisection, Dr. Thane, Inspector under the Experiments on Animals Act, concluded his evidence.

The prizes to the members of the R.A.M.C. Volunteers at Manchester were given away last Saturday by Sir Alfred Keogh, K.C.B., M.D., Director-General of the Army Medical Service.

On the 23rd inst., the President of the Royal College of Surgeons (Mr. Henry Morris) took the chair at the annual dinner of present and past students of the National Dental Hospital and College, Great Portland Street.

Dr. Horton-Smith Hartley, M.V.O., has been appointed a physician to the Brompton Hospital for Consumption, Dr. Cecil Wall assistant physician, and Dr. Dundas Grant surgeon in charge of the throat department.

Dr. G. Norman Meachen will deliver a lecture on the place of music in the healing art before the Incorporated Guild of Church Musicians, London, in the Brinsmead Concert Hall, 18, Wigmore Street, W., at 3 p.m., on November 29th.

Last week the London Courts were occupied with the re-trial of the notorious Cardiff case, in which two local medical men, Dr. Skrime and Mr. Lynn Thomas, were sued for £2,000 damages for alleged improper treatment of a fractured humerus. The case was adjourned until to-day.

The treasurer of Guy's Hospital has received two anonymous donations, of £200 and £10 respectively, towards the fund for the endowment of medical education and research at Guy's Hospital.

A CLINICAL LECTURE
ON
THE DECHLORIDATION TREATMENT IN CARDIAC AND RENAL DISEASE.

By Professor F. WIDAL, M.D.,

Physician to the Paris Hospitals.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

A SUBSTANCE indispensable to life, chloride of sodium plays an important part in the organism. The blood and lymph contain a certain fixed proportion which ensures the constancy of the osmotic tension in the tissues and fluids of the body.

In this latitude the average man consumes about half an ounce of salt daily, to which must be added some 200 grains added to his food for cooking purposes. This quantity is greatly in excess of physiological requirements, and most of the salt ingested passes through the organism without having served any useful purpose.

Under normal conditions the ingestion and excretion of the chloride are fairly balanced. Any addition to the quantity taken is followed by an increase in the output until equilibrium is re-established. *Per contra*, when an organism has been deprived of salt and has become impoverished, the first supplies are added to the reserves until these have reached their normal standard.

Variations in the chloridation of the organism entail variations in the hydration of the tissues, as is readily shown by periodical weighing. In the normal subject this variation does not exceed three to four pints, while in respect of the chlorides the variation limit is about five drachms. This equilibrium is so constant that in the healthy an excess of chlorides is not followed by hydration, owing to the prompt excretion of the salt.

Since the ebb and flow of the "organic water" is determined by the chloridation, it is easy to conceive that when the kidney is impermeable much larger quantities of salt may be retained, leading to hydration of the tissues and œdema.

The excess of chloride does not remain in the blood, but passes into the tissues, whither it takes with it a certain proportion of water, and in patients in whom the chlorides are inadequately excreted the excess is found in the œdematous serum (Achard). This fact may be viewed in contrast with the accumulation of urea which takes place in the blood. The administration of salt in certain cases of Bright's disease will suffice to determine œdema, so that it constitutes a dangerous article of diet for them and must be withheld.

The dehydrating action of the dechloridation treatment in the subjects of Bright's disease can be demonstrated with the precision of a laboratory experiment. In one case, for instance, an attack of œdema and albuminuria could at any moment be precipitated by a milk diet, symptoms which as rapidly cleared up when a regimen of bread, potatoes, and red meat was substituted. The explanation is that the 150 grains or so of salt contained in the milk rendered it a pernicious aliment, while the suppression of salt in the meat diet rendered the latter a very wholesome one.

Hydration secondary to chloride retention takes place in two stages. It is already far advanced when its existence is manifested by perceptible œdema. That stage is preceded by a period of progressive hydration not associated with any visible sign. This may reach 10 or 11 pounds. Daily weighings reveal the existence of this pre-œdematous period, and enable us to foretell with considerable accuracy the probable date of the appearance of clinically perceptible œdema; in fact, systematic weighing yields information quite as exact as the chart of urinary chlorides, and shows whether the salt ingested is or is not retained.

Manifest œdema that invades and distends the subcutaneous tissues is the least alarming feature of the hydration process. Vastly more injurious is the invisible œdema revealed by the scales. Permeating the various organs, it may give rise to visceral symptoms with which we are familiar in uræmia, and which are due to chloridæmia, but by this term we mean a state of chloride-retention, and not its actual presence in the blood.

This visceral chloridæmia may be manifested by dyspnœa, vomiting, diarrhœa, headache, Cheyne Stokes' respiration, attacks of eclampsia, according as the incubus falls upon the lungs, the digestive apparatus, or the nerve centres. The powerful and immediate effect of dechloridation proves that these symptoms belong to the state of chloridæmia.

Even albuminuria is often influenced by the richness of a diet in salt. In many cases it will be found to rise and fall in proportion to the amount of salt taken. In this case it is a renal manifestation of the chloridæmia. My view is that there is local œdema of the kidneys, which in some patients increases the albuminuria and intensifies the chloride retention.

The impermeability of the kidneys for chloride of sodium is only comparative; it varies in different individuals, and in the same subject at different periods of the disease. The impermeability may be very pronounced, for in some renal patients the kidneys only excrete a few grains of chloride in the twenty-four hours. The kidneys may be equal to the excretion of this small quantity of chloride, and if this amount be not exceeded in his food there will be no retention, no chloridæmia, no œdema. Give an excess of chloride, and as it cannot be got rid of by the kidneys, it will accumulate in the tissues and cause œdema.

The recognition of the comparative impermeability of the kidney in respect of chloride of sodium explains why a chloride-free diet, in addition to its readily understandable preventive action, exerts such a remarkable curative effect. If in the case of a subject of renal disease who is waterlogged we impose a chloride-free regimen, the infiltrated liquids are driven off by the cardio-vascular impulse, and the reserves of chloride are then reduced by the difference between the quantity of chloride that the kidney can pass and that taken in the food. In other words, there will be a chloride discharge in spite of the comparative impermeability of the kidney, and this will be accompanied by de-hydration and subsidence of the œdema. The milk diet, which conveys more chloride than many renal subjects can eliminate, is therefore less beneficial in such cases than a chloride-free diet, even though it comprises meat.

The dechloridation and dehydration that take place under the influence of a low-chloride diet are often very profuse, and when the process has been set going the chlorides may continue to flow freely from the tissues to the kidneys, and, after all trace of œdema has disappeared, the permeability of the kidneys for the chlor de may remain adequate for many months. In other instances the dechloridation takes place more gradually, and when such is the case the chloride-free diet must be maintained very strictly for a long time under penalty of a gain in weight on the least excess. Some patients are so sensitive that they become œdematous even on a milk diet.

Speaking generally, then, the curves of chloridation and hydration oscillate in the same directions in renal subjects, the richness of the œdema liquid in chloride being about the same as that of the serum, viz., five

or six parts per thousand. Sometimes, however, there is a more or less marked divergence between the degree of hydration and the intensity of the chloride retention, the patient retaining much more salt than water. This is specially seen in the subjects of interstitial nephritis, who are little liable to œdema, yet accumulate chlorides (dry retention). The explanation may be that in this case the chlorides are retained in combination with the albuminoids.

In some cases of Bright's disease there is marked disassociation of the eliminatory functions of the kidney, which, though retaining part of the chlorides, passes normal quantities of phosphates and urea, but we must remember that while urea tends to accumulate in the blood, the chloride on the contrary tends to accumulate in the tissues. This explains how it is that the proportion of chloride in the blood serum varies very little whatever the degree of chloride retention.

The quantity of urea contained in the blood stands in a certain relationship to the amount of albumen ingested, and we are thus enabled to establish an "index of urea retention." When, however, the proportion of urea in the blood attains a high figure, 50 to 60 grains per litre, we may infer the existence of marked retention of urea without enquiring the amount of albumen ingested. These figures, however, can only be reached at the terminal stage of the disease, consequently the quantity of urea present in the blood furnishes an important element of prognosis. Whatever the degree of infiltration and the gravity of the general symptoms, if the proportion of urea in the blood is approximately normal, or at any rate inferior to 15 grains per litre, we are justified in hoping much from dechloridation, whereas if the proportion of urea exceeds 30 grains per litre the prognosis is of the gravest.

It is not claimed for the dechloridation treatment that it can avert all the accidents to which the victims of chronic renal disease are liable, but it enables us to combat and to avert certain formidable complications which *per se* may cause the patient's death. In the subjects of chloride retention there are two distinct indications: one is to rid the organism of the chloride and water that clog the organism, the second is to draw up a regimen in which the quantity of chloride ingested is proportioned to the permeability of the kidney for the salt.

On commencing the dechloridation treatment of a person suffering from renal disease, we must begin by taking his weight and putting him on a strict chloride-free diet. The loss of weight will enable us to estimate the effects of the treatment on the œdema, visible or not, of the subject.

It is easy enough to establish the total amount of chloride ingested: if the patient is on a milk diet we have only to calculate 1 gramme 60 centigrammes per litre; if he is on a mixed diet without the addition of salt, we may reckon that he is taking 25 grains of natural chloride; while on certain restricted diets the quantity may fall to 15 grains daily.

The loss of weight may take place in some instances from the very commencement of the treatment, and that indicates a comparatively satisfactory degree of permeability; or the dechloridation may only take place slowly, the weight remaining stationary for some days, the grand discharge being delayed for a time. The chloride discharge takes place more slowly in patients who get up part of the day than in those who remain in bed.

The process of dechloridation may come to a stop, and some œdema remain which cannot be got rid of. In that event we must call diuretics to our aid. It is particularly apt to fall short in persons in whom the œdema is of long standing.

When dehydration is complete (*i.e.*, when the weight continues to fall after the disappearance of all trace of œdema) and the weight remains stationary for several days following, we may then try within what measure it is safe to give salt, proceeding, however, with the greatest prudence. We may begin by adding 40 or 50 grains of salt daily to his food; if the salt is duly eliminated and there is no increase of weight we may gradually raise the dose to 80, and by-and-bye to 160 grains, by which time the kidney may have recovered a comparatively free permeability for chloride, but it behoves us to remain rather below the limit of permeability.

The drugs usually associated with the dechloridation treatment are theobromine and its derivatives. Squills and nitre have only a trifling effect on renal patients, acetate of potash is rather more active, but its effects are uncertain. Theobromine, then, is the drug to be preferred, but it is unnecessary so long as diuresis takes place under the sole influence of the dechloridation, and it is unwise to seek to rid a renal subject of more than three pints of his hydration water in the twenty-four hours. In any event, the use of theobromine will not dispense with the necessity for a chloride-free diet.

The chloride-free regimen allows us to provide the patient with a dietary to his taste without losing sight of the object we have in view. Ordinary bread contains between 60 and 120 grains of salt to the pound. Saltless bread, which can be made without difficulty, does not contain more than 8 grains to the pound. Meat contains on an average 8 grains to the pound. It may be taken raw, grilled, or roasted, without salt, but with as much butter as desired. Red meats are in no wise injurious. Fresh water, fish, eggs, fresh butter and cream may be given. Vegetables, especially potatoes, rice and salads, also enter into the scheme. By using certain condiments we can effectually mask the absence of salt. Sweetmeats, pastry, fruits and jams are permissible, and chocolate is the more beneficial in that it contains theobromine. We must not authorise more than four pints of liquid in the twenty-four hours. Tea, coffee, beer, and even wine may be allowed, if taken in moderation.

The properties of milk in the treatment of certain forms of nephritis have long been known, and it owes its effects no doubt in great measure to its poorness in salt—in fact we have been carrying out the dechloridation treatment without knowing it. We must not forget that milk is a food which may, under certain conditions, suffice to maintain the nutrition of a patient for a time. But if we give milk to the subjects of Bright's disease regardless of quantity we may be giving a diet far too rich in chloride, and in any case too rich in albumen and water for many of them. The quantity of milk required to maintain nutrition contains close upon four times more chloride than a mixed diet fulfilling the same purpose. It contains three quarts of water and at least four ounces of albumen, that is to say, far more than the mixed diet.

The various chloride-free regimens, while enabling us to bring about the elimination of the surplus chloride and to prevent retention, enable us to devise dietaric to suit the requirements and tastes of the patient without infringing the rules that direct the choice of food for the subjects of renal disease.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week will be by T. Gillman Moorhead, M.D., F.R.C.P., Physician to the City of Dublin Hospital, on "Post-Traumatic Neuroses."*

THE Spanish Minister of the Interior has laid before the Senate a Bill providing for the regulation of the labour of women and children, and for the creation of a national institute of social thrift.

AT a meeting of the Medico-Psychological Association of Great Britain and Ireland on November 15th, Dr. Robert Jones, of Claybury Asylum, was presented with an illuminated address in acknowledgment of the services which he has rendered to the Association as Honorary General Secretary and President.

ORIGINAL PAPERS.

ON THE TREATMENT OF DIABETES WITH SECRETIN. (a)

By J. R. CHARLES, M.A., M.D.CANTAB., M.R.C.P.,
Assistant Physician to the Bristol Royal Infirmary.

BAYLISS and Starling have demonstrated that when hydrochloric acid comes into contact with the epithelial cells of the duodenum and upper part of the jejunum, a substance is found therein to which they gave the name secretin. This substance is carried by the blood stream to the pancreas, on the external secretion of which gland it acts as a specific stimulant. The secretin is only formed in health, when free hydrochloric acid is passing along the duodenum, which only occurs in the presence of food.

The idea has been promulgated that it is possible, since secretin acts as a specific stimulus to the visible external secretion of the pancreas, that it may also act as a similar stimulus to the assumed internal secretion. By many it has been supposed that the internal secretion is formed in the cell-islets of Langerhans, but this appears to be by no means certain. It has been shown by Dale, who believes that these islets are derived from the ordinary alveolar cells, that there is every transitional stage between the alveolar cells and the islets. Moreover, he has shown that the proportion of islet tissue can be much increased by prolonged stimulation of the gland by secretin, and he regards the islets as cells in a state of exhaustion. If, therefore, there is only one type of secreting cell in the pancreas to elaborate both the external and internal secretions, it would appear to be not unreasonable to presume that both secretions might be stimulated by the same excitant.

A paper on the treatment of diabetes by acid extract of duodenal mucous membrane was recently published in the *Biochemical Journal* by Moore, Edie, and Abram. As these authors point out, even if it be granted that the duodenum yields a chemical excitant for the internal secretion of the pancreas, and that in the absence of this internal secretion glycosuria occurs, then there are three places at which a breakdown may occur, resulting in diabetes. Firstly, at the duodenum, on account of the non-secretion of the excitant; secondly, at the pancreas; thirdly, in the oxidising tissues, such as the liver and muscles. Perhaps also it might be added that in some cases a defective supply of hydrochloric acid might be the cause of the failure of the elaboration of the secretin.

It must not, therefore, be supposed that all cases of diabetes will be benefited by the administration of secretin. In the paper above referred to five cases treated with secretin are mentioned. In two the results were negative, but it is stated that the periods of observation were short and the doses insufficient. In the third case, a man, æt. 25, after administration of the extract for some weeks the sugar fell in amount and gradually disappeared entirely. The patient increased in weight and the polyuria disappeared. Unfortunately, a few months later, after leaving the infirmary and giving up his extract, he developed phthisis, the sugar reappeared, and he shortly afterwards died. Another case was that of a boy, æt. 7, in whom the sugar excretion gradually fell, until after five and a half weeks' treatment it was entirely absent, and remained so, even after the treatment had been suspended. In a further case, a girl, æt. 9, the sugar entirely disappeared after three weeks' treatment.

During the last few months I have treated three patients by this method, but unfortunately with entirely negative results. The cases, even though failures, are, however, I think, worth recording. At present it is quite uncertain what type of patient suffering from the disease is likely to respond to the treatment, yet if both negative and positive cases be recorded, some facts may be brought to light which may make this point more clear.

(a) "Bristol Medico-Chirurgical Journal," September, 1906.

Case I.—William T., æt. 41, miner. Admitted February 5th, 1906, suffering from great thirst and hunger, weakness and loss of flesh of seven months' duration. No complications.

Date.	Amount of Urine in ounces.	Total Daily Amount of Sugar in grains.	Urea.	Weight.
				st. lb.
Feb. 6	19+	26.25 grs. per oz.	10 grs. per oz.	8 0
,, 8	Administration of secretin began.			
,, 8	80	2,800	700	—
,, 12	74	1,420	841	—
,, 15	64	704	755	—
	Secretin omitted from 15th-17th			
,, 17	60	570	864	8 1
,, 20	48	734	691	—
,, 25	56	852	1,015	8 1
March 1	60	780	929	—
,, 5	60	783	738	8 1
,, 7	64	832	612	—
,, 12	54	702	713	8 2
,, 16	74	1,296	1,036	—
,, 18	62	920	988	8 2
	Secretin omitted.			
,, 22	78	1,014	1,248	—
,, 26	74	1,295	1,036	8 2

NOTE.—Neither acetone nor diacetic acid were present in this case, except a trace of acetone on March 5th.

Case II.—George K., æt. 27, gardener. Admitted March 3rd, 1906, for thirst and polyuria of eighteen months' duration, with loss of flesh. There was no complication.

Date.	Amount of Urine in ounces.	Daily Amount of Sugar in grains.	Urea.	Weight
				st. lb.
Mar. 4	64	2,240	—	10 1
,, 6	52	840	765	—
,, 8	48	704	701	—
,, 11	48	420	764	—
,, 13	64	830	1,066	10 1
,, 17	58	1,270	1,160	10 1
,, 19	Administration of secretin began.			
,, 19	74	1,295	1,180	—
,, 21	62	1,170	1,302	—
,, 26	74	888	1,406	10 2
,, 30	72	950	1,260	—
April 1	72	1,160	—	—
,, 5	65	975	1,278	10 1
,, 9	68	1,020	1,156	—
,, 13	70	910	1,330	—
,, 16	Secretin solution stopped.			
,, 18	"Antiglucosine" substituted.			
,, 18	58	870	989	—
,, 22	74	806	1,358	10 2
,, 26	58	826	1,282	—
,, 30	58	754	913	—
May 4	60	780	1,181	10 2
,, 9	60	780	1,050	—
,, 21	52	676	884	—
,, 25	59	826	1,284	—
June 5	56	980	840	10 2
,, 11	48	720	802	—
,, 13	60	780	1,140	—

NOTE.—Neither acetone nor diacetic acid were present in this case.

Case III.—John W., aged 53, shopkeeper. Ad-

mitted November 16th, 1905, and discharged January 16th, 1906. Complained of thirst, excessive appetite, polyuria, dryness of skin, and loss of weight of three and a half years' duration. This man was treated by diet, codeia and aspirin. He went out unrelieved. A quantitative and qualitative investigation of his urine was made twice a week. The analyses remained remarkably constant. Acetonuria was present throughout. Comparing the last with the first analysis, we have :—

Date.	Oz.	Sugar.	Urea.	Acetone.	Diacetic Acid.	Weight.
						st. lb.
Nov 20	84	2,499	882	Present.	Absent.	8 10
Jan. 15	104	2,631	676	Present.	Present.	9 0½

Since his discharge he has been kept under constant observation, and on February 6th secretin treatment was commenced. As the daily amount of urine was only roughly estimated, the amount of sugar was calculated by grains per ounce. The following figures show that little improvement took place. Acetone disappeared on May 15th, but rapidly returned :—

Date.	Grains per oz.	Date.	Grains per oz.
Feb. 13	28.3	April 20	Began "Antiglucosine."
,, 27	28.9	May 8	26.2
Mar. 3	26.8	,, 15	29.2
,, 9	28.6	,, 21	21.4
,, 16	31.4	June 11	39.2
,, 23	25.7	,, 21	Stopped "Antiglucosine."
,, 30	32.2		

The "antiglucosine" mentioned above is an acid extract of duodenal mucous membrane, and differs from the solution of secretin first used in being made freshly every other day. Solutions of secretin are known to become inert on keeping, and it was thought that the negative results obtained with the first solution of secretin might be due to the fact that it had been kept too long, and hence "antiglucosine" was substituted. The treatment has for the present been discontinued, as it was found that the solution was liable to undergo decomposition on very hot days.

The most satisfactory results obtained by Moore, Edie, and Abram were in two children, whereas these patients were all adults. The diet while the observations were being made was, of course, kept constant.

APPENDICO-ENTEROSTOMY.

By SETON PRINGLE, M.B. (Univ. Dub.), F.R.C.S.I.,

Surgeon to Mercer's Hospital, Dublin.

SOME years ago it was the fashion to unhesitatingly condemn the vermiform appendix as a useless and dangerous organ which it was the duty of every surgeon to remove on the slightest provocation. However, more recently we have come to recognise that it is not an organ of merely developmental significance, and that not only has it its part to play in the normal processes of the body, but also that it may be used by the surgeon in several ways in treating diseased or abnormal conditions of the intestines. Sir William Macewen (*a*) in his Huxley Lecture for 1904, made a systematic effort in its defence when he showed that at least it had a possible function "of value in digestion." Before this date the operation of appendicostomy, which now holds a recognised position in surgery, had been advocated by Keetley (*b*), and had been performed several times. Although this operation gives an easy and safe method of applying lavage to the great intestine, the difficulty of passing a tube up through the ileo-cæcal valve, and thus enabling us to also treat the lower ileum, was recognised. However, quite recently Ewart (*c*) has described in detail a method by which this may be accomplished. No doubt this is quite a feasible procedure in skilled hands in the majority of cases, but I think it will never be without an element of risk in ulcerated conditions of the gut, as a stiff instrument is required, and an element of doubt exists as to when the valve has been successfully passed, since the only *positive* indications of this fact are the actual palpation of the catheter through the abdominal wall, and the obtaining a skiagram of the instrument with a stillette in position. Recognising the limitations of appendicostomy, I have in the case about to be reported employed a procedure which has as far as I know not yet been described, and which adds another to the possible uses of the appendix. The operation briefly consists in implanting the opened tip of the appendix into the lower ileum, bringing out and fixing the middle third of the organ to the skin, then, after the wound in the parietes has healed, this loop can be opened, leaving both the lower end of the small and the whole of the great intestine easily accessible for lavage.

History.—C. J., unmarried, female, æt. 22, admitted to Mercer's Hospital, May 14th, 1906. Three years ago she had both her ovaries removed by a gynæcologist for double tuberculous pyosalpinx, the wound, however, suppurated, and a ventral hernia developed, while she continued to complain of considerable pain in both iliac fossæ. In April, 1905, when she came under my care, I operated for the cure of the hernia, and then found great matting together of the intestines in the pelvis, and on endeavouring to separate these adhesions I came on unmistakable evidence of tuberculosis. A few weeks after her discharge from hospital with the hernia cured, the pain in the iliac regions increased in severity and diarrhœa set in. From this time till last May, when I readmitted her, the diarrhœa continued, the stools numbering six to twelve per diem, fluid in character, containing mucus and occasionally blood, while she also complained of constant abdominal pain with frequent attacks of greater severity, especially referred to the right iliac fossa. For several months before readmission, she was treated in the extern department by Wright's vaccine method, and although her tuberculo-opsonic index was raised from ·65 to above normal, no appreciable improvement had taken place.

Condition on Admission.—On examining the abdomen, the only sign of importance which could be made out was tenderness along the entire course of the colon, but most marked in the right iliac fossa, where a sense of indefinite fulness was conveyed to the palpating hand.

Operation.—As we were here evidently dealing with a case of chronic tuberculosis of the intestine, I determined to perform the operation briefly

(*a*) "Brit. Med. Journ.," 1904, Vol. I., p. 873.

(*b*) "Brit. Med. Journ.," 1894, Vol. II., p. 1,112.
(*c*) "Lancet," May 12, 1904.

outlined above. In detail the technique was as follows: The abdominal cavity was opened by McBurney's muscle-splitting incision, but placed an inch or so nearer the middle line, the appendix was easily found lying to the inner side of the cæcum with the top adherent to the root of the mesentery of the lower ileum. When this adhesion had been freed, the ileum about four inches above the ileo-cæcal valve was pulled into the wound and caught in a Doyen's stomach clamp, so that its unattached border presented in the concavity of the forceps. The peritoneal cavity was then packed off with gauze, leaving only the appendix and the portion of ileum included in the clamp exposed. The next step consisted in passing a silk suture through the sero-muscular coats of the appendix about a quarter of an inch from its tip, and after making a small incision into the centre of the clamped part of the ileum, each end of this fixation suture was carried on a needle through the wall of the gut from within out, so that on tightening it the tip of the appendix would be pulled into the incision in the ileum, and fixed there (Fig. 1). My assistant then took charge of

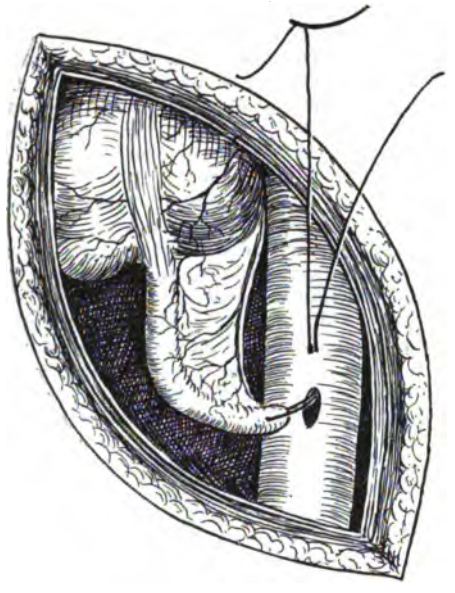

FIG. I.
Showing incision in ileum and fixation suture in position, immediately preparatory to cutting off top of appendix and tightening the suture. The clamp on the ileum and the gauze packing are not shown.

the two ends of the suture, and I, after cutting off and removing the tip of the appendix immediately insinuated its open end into the lumen of the ileum, while he tightened and tied the suture, thus fixing the opened appendix into the small gut. The line of junction was next rendered secure by two rows of continuous silk suture and the knot of the fixation suture on the peritoneal surface of the ileum buried by a few points of fine silk (Fig. II.). The clamp and protective gauze pads were then removed, and the operation area sponged with salt solution. The preceding and following steps of the operation will be more clearly understood by a reference to the accompanying semi-diagrammatic sketches. As a precautionary measure, and also to relieve tension, I fixed the ileum on either side of the anastomosis to the deep surface of the parietal peritoneum by a few stitches, and then closed either end of the incision in the peritoneum, leaving about the middle third of the appendix presenting in the depth of the wound in

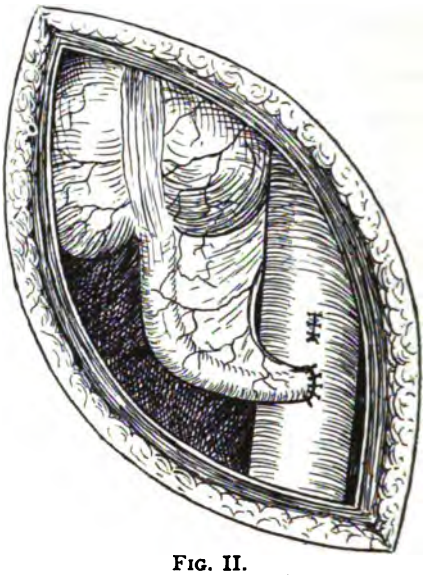

FIG. II.
(Semi-diagrammatic.)
Showing opened end of appendix fixed into ileum, knot of fixation suture buried.

the parietes and fixed there by the last loop of either continuous suture in the peritoneum, and also by a mattress suture through either flap of peritoneum, and the mesentery of the organ, which latter I tied loosely so as not to strangulate the circulation (Fig. III.). The muscles and

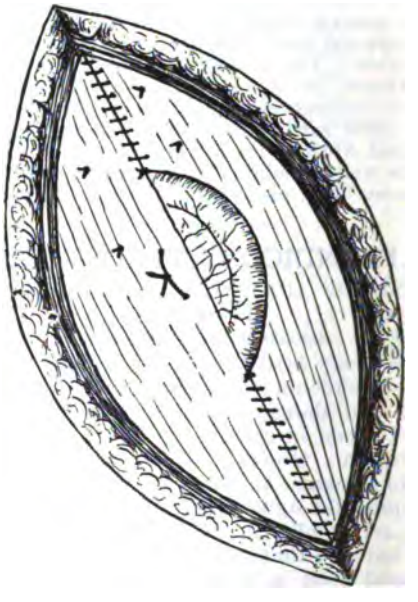

FIG. III.
(Semi-diagrammatic.)
Peritoneum closed, loop of appendix presenting and fixed mattress suture through the mesentery tied, points of suture fixing ileum in neighbourhood of anastomosis to the parietal peritoneum.

aponeurosis were then approximated by interrupted catgut sutures and finally the two ends of the skin incision closed, while the appendix was fixed on a level with the skin in the centre of the wound by four silkworm-gut stitches.

Progress of the Case.—The wound was not dressed for eight days, and was found soundly healed except for a gap in the centre, from which the loop of appendix had retracted as the stitches fixing it to the skin had lost their hold on the wall of the organ. It necessitated administering an anæsthetic to find the loop which lay at the bottom of the wound in the muscles, it was then opened by a transverse incision dividing three-fourths of its circumference, and the cut edges stitched to the skin. Since then it has been quite easy to see the two openings and to pass two No. 8 soft catheters, one into the cæcum and another into the ileum. I now daily wash out the intestines with antiseptics; the first solution I tried was a 1 per cent. silver nitrate, but as this caused intense pain it was discontinued and protargol used instead. There has never been any discharge of fæcal matter from either opening. It is yet too early to form an opinion as to the final result of the treatment.

If I am again called on to do this operation I intend to make several slight alterations in technique. It would, I think, be advisable to fix the free end of the cæcum as well as the ileum to the parietal peritoneum, as with a short appendix the tendency to retraction is marked, and also to pass a guiding suture, leaving the ends long, through the summit of the loop of appendix, so that in case of retraction the organ could easily be pulled up into the wound. If thought desirable it would, I consider, be quite sufficient to crush the tip of the appendix before insertion into the ileum, and so obviate the opening of an organ which is a favourite haunt of bacteria. With these additions I venture to hope that the procedure above described will be of value in a few selected cases, but I fear its performance takes too long to permit of its being justifiable in a weak subject—for instance, in a patient suffering from typhoid fever.

Postscriptum.—The above account of the case was written in June last, but, unfortunately, the hospital was closed down in July to allow the drainage to be overhauled, and at the same time I left town for six weeks. On resuming work I found that both the openings had closed, and consequently the treatment could not be recommenced. I therefore regret that no definite conclusion can be arrived at, although the patient appears better and the diarrhœa is limited to three or four motions per diem.

OPERATING THEATRES.

NORTH-WEST LONDON HOSPITAL.

EPITHELIOMA OF THE FLOOR OF THE MOUTH.—Mr. MAYO COLLIER operated on a case, a man, æt. 54, which proved to be one of considerable interest from the fact that he adopted a procedure formulated and published by him some 25 years ago, which he thought for simplicity, thoroughness, and freedom from danger, both during the operation and in the after treatment, leaves little to be desired. Mr. Collier said that here he was confronted with a state of things in which one of two courses only could be followed. No half measures were permissible In this case the floor of the mouth was extensively involved by a new growth about which there could only be one opinion. It was not syphilis; there was no history of syphilis; and the amount of new growth as compared with the ulceration was disproportionate. It was hard; the sublingual glands were involved; and it had already invaded the tongue in the neighbourhood of the frænum. The growth had started as a small ulcer on the frænum linguæ, and had gradually, within the last six months, attained its present dimensions. There were enlarged glands to be felt in both sub-maxillary triangles The patient was not suffering much pain or inconvenience, but the presence of the growth was evidently telling on his strength. No question of the growth being tuberculous could be entertained. No organic disease could be detected in the thoracic or abdominal organs. Mr. Collier said that under these circumstances, if the whole growth could be got well away, and if the whole of the glands and cellular tissue in the submaxillary triangles, and in the neighbourhood of the mylo-hyoid and geniohyoid muscles could be explored and removed, a good prospect of prolonging the patient's life in fair comfort and usefulness existed. He quoted two cases in which he had performed a similar operation to the one he was about to do, seven and five years ago respectively. One of the patients had now lived for seven years in comparative health, whilst the second had died only quite recently from pneumonia following influenza. In neither case did the disease reappear. These, as well as other cases, were, he thought, very encouraging, and made one look forward to and hope for the time when, if a thoroughly efficient and complete operation was the rule in these cases, many more lives would be prolonged than was the present experience. An incision was made on each side from the tip of the mastoid process, curving downwards to the centre of the great cornu of the hyoid bone and upwards to the prominence of the lower jaw one inch external to its centre. After dividing the skin, superficial fascia, and platysma, the deep fascia covering the submaxillary gland was incised throughout the entire length of the skin incision. The submaxillary gland was next removed in its entirety, not forgetting its deep portion extending to the floor of the mouth as well as that part which is tucked in between the mylo-hyoid and the genio-hyo-glossus. The facial artery and vein were next ligatured in two places below and above the gland. Any gland or cellular tissue existing in this space was carefully removed to the last speck. The lingual artery was now found by a little blunt dissection and tied, the site of the ligation and the empty space being lightly packed with dry ribbon cyanide gauze. The next step was to incise the mylo-hyoid muscle on each side transversely near the prominence of the chin up to and as far as the outer border of the genio-hyoid. This being done, the skin surface of the mylo-hyoid was carefully examined by insinuating the index finger one each side between the skin and the muscle, and removing the smallest glands that could be detected. A similar search was made between the mylo-hyoid and the under-surface of the genio-hyoid. The fingers were next insinuated between the upper surface of the genio-hyoid and the genio-hyo-glossus, and any glands here detected were removed. The next step in the operation was to free the genio-hyoid from the genio-hyo-glossus completely from the hyoid bone to the genial tubercle, so that the finger was quite free to pass from front to back. A little manipulation now freed the whole floor of the mouth from its infra-maxillary attachment. Up to this point the mouth had been entirely at the disposal of the anæsthetist, and

no anxiety had been entertained as to blood finding its way into the mouth and larynx. The mouth was now opened, and a Smith's gag placed as far back as possible and given in charge of a trustworthy assistant, whose duty was to see that the gag did not invade the cavity of the mouth and did not slip at a critical moment, and, whilst doing this, to concentrate his attention on the gag and not on the operation. A stout double ligature having been placed transversely through the root of the tongue one inch from the epiglottis, Mr. Collier, guiding his blunt-pointed curved scissors with his left index finger below, cut through the mucous membrane of the mouth as well as the genial attachment of the genio-hyo-glossus in the mid-line behind the previously removed incisor teeth. With the index finger as a guide, the scissors were made to detach the mucous membrane from the lower jaw as far as the angle on both sides. The tongue, floor of the mouth, as well as the entire growth, were now quite free, and were only held attached to the hyoid bone and the glosso-epiglottic folds. With the linguals ligatured, the tongue and floor of the mouth were now, with complete confidence, drawn well forward and cut away close up to the epiglottis with a pair of curved scissors without the loss of a single drachm of blood. A temporary stout thread, Mr. Collier said, may be placed transversely through the stump previous to this division, but this step was only needful as a precaution in case of bleeding from the stump, which is extremely rare. All oozing being arrested by packing ribbon cyanide gauze into the hollow thus left, two drainage tubes one and a half inches in length were joined together by an intervening double strand of thick silk one inch in width. The silk juncture was placed over the genio-hyoid muscle, and the two tubes were brought out of the inner angle of the wound below in the cleft made in the mylo-hyoid muscle. The gauze packing was then removed, and the skin incision carefully adjusted with fine silkworm gut and horsehair. The wound was dressed with layers of cyanide gauze, and a piece of protective mackintosh was placed over the dressing, so that the two draining tubes should pass through it—being accurately adjusted so that no drainage should soil the upper dressing. Further dressing and bandages having been applied, the patient was removed to bed, instructions being given that he be kept continuously in a semi-prone position. With this precaution Mr. Collier said there would be no tendency for the stump to fall backwards; there would be natural drainage of the wounds by gravity; the mouth could be washed out every hour without risk of overflow into the larynx or œsophagus, and the patient can expectorate and feed with greater ease. Mr. Collier pointed out that there had not been the slightest hitch or difficulty throughout the whole procedure. The linguals were found in less than five minutes. There was practically no bleeding, and the patient left the table in one hour and fifteen minutes from the commencement of the operation, little the worse, as far as his pulse indicated, for his severe ordeal. Mr. Collier said the operation was simple and deliberate, and was capable of doing all that was desired, namely, removing the entire growth with all visible glands. The secret of the success was to retain the patient in the semi-recumbent position, and to wash the sloughing cavity (left by the removal of the floor of the mouth) out at first every hour with a lotion of permanganate of potassium, half a grain to the ounce.

The tubes were removed 48 hours after the operation. The man was then feeling well and comfortable. The wound in the skin had healed by first intention, the pulse was good, and the temperature normal.

It is satisfactory to state that the subsequent progress has been uninterrupted, and the man is now, some days after the operation, practically well.

CHELSEA HOSPITAL FOR WOMEN.

ABDOMINAL MYOMECTOMY AFTER CONFINEMENT.—Dr. ARTHUR GILES operated on a woman, æt. 37, a patient of Dr. Carson Smyth's. Her history was that four years previously she had been the subject of an extra-uterine pregnancy in the left tube. Intra-peritoneal rupture occurred, and Dr. Giles operated upon her at the Tottenham Hospital. Her first pregnancy after the operation began about ten months ago. During its course, Dr. Smyth discovered a tumour in the upper part of the uterus; he considered that labour would not be interfered with, and his anticipation proved correct. Six weeks after the confinement he sent her to the Chelsea Hospital for Women. On examination, a firm tumour, the size of two fists, was found connected with the uterine fundus. When the abdomen was opened the tumour proved to be a large pedunculated fibroid. Myomectomy was done by cutting through the peritoneum round the pedicle, shelling out the tumour, and securing the stump with ligatures applied by transfixion. The abdomen was closed by the usual three-layer method. On cutting across the tumour it was found to be a soft reddish fibroid in a state of necrobiosis. Dr. Giles remarked that there were three points of interest about this case. In the first place, it justified the policy of leaving the non-gravid tube when operating for extra-uterine pregnancy. At the recent meeting in Toronto some of the speakers took up the position that both tubes should always be removed because of the risk of second extra-uterine pregnancy, but the risk of a subsequent pregnancy occurring in the other tube was not, he thought, great enough to warrant its removal in every case. The second point of interest was the fact that, as the abdomen had been opened before, some estimate could be formed of the maximum time that this fibroid had taken to grow. Although it was of considerable size it had been growing for certainly less than four years. In the third place the case had a bearing on the question of the removal of fibroids during pregnancy; he thought it might be taken as a general rule that fibroids connected with the upper portion of the uterus might be safely left until after confinement, unless any acute symptoms supervened, but when the fibroid was attached to the lower part of the uterus it might require to be dealt with during pregnancy in order to minimise danger during labour. With regard to the operation itself, the tumour, he pointed out, was a very suitable one to be dealt with by myomectomy because it was solitary and pedunculated and the uterus had given quite recent evidence of capacity for pregnancy.

The patient made an uninterrupted recovery.

TRANSACTIONS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON.

MEETING HELD NOVEMBER 23RD, 1906.

The President, Mr. CLUTTON, in the chair.

Dr. HALE WHITE proposed and Dr. Frederick Taylor seconded a resolution to the effect that the Council's advice to the Society to join the proposed Union of Medical Societies be adopted. It was carried *nem. con.*

DR. WALTER CARR read a paper—

A CASE OF HÆMORRHAGE INTO THE PREFRONTAL LOBES OF THE BRAIN.

A man, æt. 53, was admitted to the Royal Free Hospital in a semi-comatose condition, having suddenly become unconscious about seven hours before. The pulse was 56 and of very high tension; the urine boiled almost solid with albumen and contained a considerable quantity of sugar, but did not give the reactions for diacetic acid and acetone. Otherwise the results of physical examination were quite negative; there was not the slightest indication of hemiplegia or of any unilateral symptoms whatever. The man gradually improved, and after two or three days completely recovered consciousness; about the seventh day, however, he again became drowsy, his temperature slowly rose, and he died comatose on the ninth day from the onset. After the first day or two the sugar completely disappeared from the urine, and only an occasional trace of albumen was present.

At the *post-mortem* it was found that a small saccular aneurism on the anterior communicating artery had ruptured into the left prefrontal lobe, and that the hæmorrhage had subsequently extended (probably only shortly before death) into the right prefrontal lobe. The kidneys showed an early stage of chronic interstitial nephritis. In this case, despite the presence of sugar in the urine, the patient's aspect was not that of diabetic coma, but uræmic coma seemed at first very probable. The suddenness of the onset was in favour of apoplexy, but in the absence of any indication of a unilateral cerebral lesion this scarcely seemed a justifiable diagnosis.

Dr. A. E. GARROD recalled making a *post-mortem* examination on a similar case. The patient, a man, recovered completely from the affection, but died of a second hæmorrhage.

Dr. JOHN FAWCETT read a paper on a case of

ACUTE PERITONITIS WITH FAT NECROSIS: NO DISEASE OF THE PANCREAS.

The patient, a female, æt. 59, was admitted into Guy's Hospital under Dr. Hale White, for severe abdominal pain and vomiting, which symptoms had come on suddenly on the previous day. The abdomen was not distended nor rigid, but was extremely tender on palpation in the upper part. Laparotomy was performed later, but no pathological changes were found except areas of fat necrosis in the great omentum, and a small amount of extravasated blood. The patient died the following day.

Autopsy.—A recent general acute peritonitis was present. A widely spread fat necrosis existed, and there was a recent small hæmorrhage in the lesser omentum.

The pancreas was firm; no abnormal changes visible in it, even under the microscope. Cultivations made from the spleen and from the blood in the right side of the heart gave a pure growth of the bac. coli comm.

Remarks.—Although most cases of fat necrosis are associated with disease of the pancreas, yet there are a number on record in which no lesion of the pancreas has been found. In the Guy's Hospital *post-mortem* records there were three such cases during the past six years, but in no one of these was a microscopical examination made. In these three cases the condition was as follows:—

Case I.—Woman, æt. 33. Admitted for acute abdominal pain. Laparotomy performed twelve hours from onset of symptoms; nothing found.

Autopsy.—Numerous areas of fat necrosis in omentum and appendices epiploicæ.

Case II.—Woman, æt. 45. Sarcoma of cervical glands: general sarcomatosis. Died of hæmatemesis.

Autopsy.—A healed duodenal ulcer 3 cm. below pylorus, firmly attached to pancreas. Many areas of fat necrosis over visceral peritoneum, especially in neighbourhood of pancreas.

Case III.—Man, æt. 43. Admitted with a perforated gastric ulcer; laparotomy performed and ulcer sutured. Death took place the following day.

Autopsy.—A recent acute peritonitis, and, in the fat of the great omentum, necrotic fat areas.

If the statement be accepted that fat necrosis is always a consequence of pancreatic disease, then such a case as the one here recorded is exceedingly difficult to explain. It may be that an obstruction to the duct or an interference with the blood supply in some cases will result in a freeing of the fat ferment. However, under present conditions of knowledge the pancreatic fat ferment cannot be said satisfactorily to explain either the case related, or those in which there is a necrosis of the pericardial or subcutaneous fat.

Mr. CLUTTON referred to the complexity of the problem, and instanced the cases of slight injury, in which laparotomy shewed extensive necrosis, and which recovered.

Dr. HALE WHITE said that it would be a valuable step if we could diagnose such cases and so prevent a needless operation. In the present case the reason why he had not called in a surgeon sooner was that forty-eight hours after the onset of symptoms the pulse was 90, and there was no rigidity or distension of the abdomen. He commented on the occurrence of severe pain at the onset.

Dr. CECIL BOSANQUET suggested that even when the pancreas was found to be normal it might be the source of the mischief by means of a small hæmorrhage at its border. In support of this was the fact that in many cases in which fat necrosis and hæmorrhagic pancreatitis coexisted the lesion was primarily a hæmorrhage and not an inflammation, and also the fact that so many of the cases such as that of Dr. Fawcett's showed the presence of blood in the peritoneum.

Mr. W. G. FEDDON narrated a similar case in which he had performed laparotomy. A brown fluid was found in the abdomen. The patient recovered.

Dr. H. S. FRENCH and Mr. W. G. SPENCER also discussed the paper.

Dr. FAWCETT replied, and especially referred to Mr. Spencer's suggestion that accessory lobules of the pancreas might be present in these cases, the main part of the pancreas being healthy.

Mr. W. G. SPENCER described a case of

CYSTIC DILATATION OF THE LOWER END OF THE URETER

containing calculi which became engaged intermittently in the urethra. The patient, a young man, had for six years suffered intermittently from difficult micturition and nocturnal incontinence. Generally he presented no symptoms whatever, and the usual evidences of renal and bladder calculus were absent. No abnormal physical signs were noted until he was examined bimanually under an anæsthetic, when a hard mass was found slipping about within the bladder. On the patient straining, this became engaged in the urethra like an impacted calculus. By perineal section a cyst containing three calculi was found tightly grasped in the sphincters. The pedicle of the cyst was traced up to a portion of the orifice of the left ureter, where the pedicle was burnt off. The man had now no urinary trouble.

Mr. CLUTTON read the notes of a similar case that had occurred in a man of twenty. Sudden anuria and pain in the right side were the symptoms. There had been no previous history of stone. After suprapubic cystotomy the patient got quite well.

Mr. MAKINS had seen a similar case successfully operated on many years before, Lateral lithotomy was done.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF MEDICINE.

President: J. M. REDMOND, Pres. R.C.P.I. Sectional Secretary: F. C. PURSER, M.D.

MEETING HELD FRIDAY, NOVEMBER 9TH, 1906.

The PRESIDENT in the Chair.

SO-CALLED FUNCTIONAL CARDIAC MURMURS.

DR. TRAVERS SMITH read a paper on the above, dealing especially with the pulmonary systolic functional

murmur, or the common "hæmic" murmur. He reviewed the current theories to explain this murmur, and showed how they could all be refuted on ætiological, clinical, or autopsical evidence. It was urged that this murmur had been too closely associated with anæmia; in fact, it had been generally explained on an anæmic basis. The author laid stress upon the facts that, even apart from anæmia, the murmur was common in neurotic individuals, in those who were "out of training," in connection with many fevers (especially during convalescence), in all of which conditions one might expect a "flabby" state of the body musculature and lowering of tone. In most of his cases the author had established a history of some strain, often inconsiderable to any normal individual. Under these conditions the ventricles of the heart were liable to suffer, especially at the weakest point of their outer boundary wall—namely, the infundibulum, or conus arteriosus. The weak myocardium being strained resulted in incomplete systole or actual dilatation of the infundibulum, the blood being forced from the body of the right ventricle at systole through the unobliterated cavity of the infundibulum into the pulmonary artery. This, Dr. Travers Smith submitted, was the cause of the murmur. In proof of this view he urged the following points:—(1) The murmur disappears with rest in bed, recurs if patient allowed up too soon; (2) it is best heard at the junction of the infundibulum and pulmonary artery; (3) it can be traced better downwards over the infundibulum which comes to the surface than upwards over the pulmonary artery which slopes posteriorly; (4) the murmur is heard best in expiration, because the pressure in the pulmonary artery is thereby raised with further strain on the infundibulum. The murmur can sometimes be actually produced by a prolonged expiratory phase; (5) a slight, sudden exertion, as sitting up, diminishes the murmur, as it affords a stimulus to the infundibulum to contract more energetically. Occasionally the murmur increases on sitting up, showing greater weakness of the infundibulum; (6) the murmur is commoner in youth owing to the relatively high pressure in the right ventricle as judged by the loud pulmonary second sound in youth; (7) the murmur disappears with gross dilatation of the right ventricle when the dilatation of the infundibulum fuses with that of the body of the ventricle—in fact it is not heard with a tricuspid regurgitant murmur; (8) when a functional pulmonary diastolic murmur occurs with a systolic one (the author had met two examples) it is best explained upon the hypothesis that blood remaining in the infundibulum regurgitates thence into the body of the ventricle at its commencing diastole; (9) almost invariably the area of superficial cardiac dulness is increased upwards in the presence of a pulmonary functional systolic murmur. Dr. Travers Smith urged that this view afforded the most rational explanation of the ætiology and clinical signs of the murmur.

Dr. MOORHEAD said he regretted that Dr. Smith had not given them his views on the other functional murmurs. He had himself first accepted, without much thought, the idea that the functional murmurs generally were produced by some alteration in the normal relation between the blood and the vessel wall, accepting that normal blood flows through normal vessels without producing murmurs. Very soon, however, he had to give up that idea, and he found it necessary to find some theory which would explain the murmurs heard in cases of acute endocarditis as well as the ordinary so-called functional murmurs. In such cases he could not conceive that the small vegetations that are seen on the edges of the valves were capable of preventing the valves from closing. He then took the view that functional murmurs and the murmur of acute endocarditis were due to muscular relaxation, and were functional in the sense that the muscle from its weakness relaxed, and regurgitation took place. Anything in the way of relaxation that would give rise to aortic systolic murmur—a rare condition, he admitted—would surely also give rise to a pulmonary functional murmur and to a mitral functional murmur. Although it was possible that Dr. Smith's theory would be applicable to the other valves, he was not prepared to accept it fully.

Dr. SMITH, in reply, said that Dr. Moorhead's mental phases in trying to find an explanation for functional murmurs were the same as his own. It was his intention to deal with the other murmurs in another paper. He did not think that Dr. Moorhead's suggestion, that pulmonary and mitral functional murmur ought to be present when an aortic murmur was present, was against his (Dr. Smith's) own view. The exact spot at which a murmur was heard did not indicate the seat of the murmur. He suggested that aortic systolic functional murmur, which was of extreme rarity, was to be explained by the pulmonary murmur, which was the commonest, and could be induced.

SPLENO-MEGALY WITH EOSINOPHILIA.

Dr. PARSONS read a paper on the above subject, illustrating it by a case which he showed. He described the condition of the blood and the patient's general symptoms, and gave details of the history. He said treatment by X-rays had had no appreciable effect.

Dr. ROWLETTE said he had seen the case some years previously, and the spleen did not appear to have increased in size. During observation the health of the patient had remained exceedingly good, apart from the discomfort through the weight and size of the tumour.

Dr. PEACOCKE quoted a case which turned out a case of Hodgkins' disease. The splenic tumour was simply a mass of lymphoid tissue. An operation was successfully performed, and he suggested the removal of the spleen in the case before them as a curative method.

Dr. HARVEY said he had seen cases of an ordinary type treated with X-rays with apparently very different results from those in the present cases. Such treatment was likely to have altered the pathology of the spleen considerably. The effect in animals was to destroy the lymphocytes in considerable degree.

Dr. PARSONS, replying to questions from Drs. Moorhead, Kirkpatrick, and Smith, said the patient at no time had syphilis. He did not consider the cases identical merely because they had eosinophilia. The cases were on the same level. There was no deterioration in health, no threatened shortening of life, and no inconvenience except in the weight of the tumours. Lymphocytosis was not very marked; exactly the same was found in the case of splenectomised animals, which tended to confirm his view that the two patients were functionally splenectomised. Several examinations of the blood had been made before the X-ray treatment was commenced, and there was found to be no diminution in the number of the lymphocytes. Anxious as he was to know the pathology of the spleen, he did not feel justified in recommending its removal, as no inconvenience was caused, and no further enlargement was threatened.

THE SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

MEETING HELD FRIDAY, NOVEMBER 16TH, 1906.

DR. TYSON (Folkestone) in the Chair.

A PAPER ON

PSORIASIS IN CHILDHOOD.

was communicated by Dr. James Burnet. The author considers psoriasis may differ in causation in early and adult life, and in children it is never so generalised or so scaly as in the adult. He believes every case of psoriasis in the child is due to rheumatism, and this cause is often overlooked owing to the peculiar manifestations of that disease in the young subject. He has been able to satisfy himself that in the greater number of instances psoriasis is merely a rheumatic manifestation, and he quoted two cases of psoriasis occurring in children who at the same time suffered from rheumatism and chorea. He accordingly treats every case of psoriasis with large doses of salicylate of soda or preferably aspirin. Alkaline baths and tar ointments are useful additional measures.

Drs. SPRIGGS and HIGGS showed a case of

HEMIPLEGIA IN AN EPILEPTIC

æt. 4 years, with athetosis of the arm. The hemiplegia was discovered one morning, the child having had a

fit during the previous night. The leg improved rapidly, and in two or three months he could get about. In July this year athetosis was present in both arm and leg, and it has persisted to the present time, being much more marked in the arm. There is weakness of the left side of the face and some mental impairment. The athetosis increases during excitement and ceases during sleep.

CONGENITAL DIVISION OF THE CLAVICLE INTO TWO PARTS.

A patient, æt. 12, was shown by Dr. SPRIGGS with the above deformity. Each clavicle consists of two pieces about 1½ inches long, connected together by a freely movable joint. At rest the pieces form a wide V with the apex upwards. The shoulders can be brought almost to meet in front. The X-rays showed deficient ossification of the bones; and Dr. Spriggs suggested that the ossification of the membrane bone was absent, and the two fragments represented the ossification of the two pieces of cartilage which take part in the development of the clavicle.

A CASE OF BRONCHIECTASIS IN A YOUNG CHILD was shown by Dr. WHIPHAM. The patient, æt. 2 years and 4 months, showed signs of well-marked bronchiectasis chiefly in the base of the right lung. Fingers and toes were clubbed. The condition seemed to be due to bronchitis and pneumonia, which was immediately followed by whooping cough.

LATERAL CONGENITAL FISTULÆ IN THE NECK, in a girl, æt. 8½ years, was shown by Mr. PHILIP TURNER. They were situated at the inner border of the sterno-mastoids, 1½ inches above the clavicle. The sinuses could be felt extending upwards nearly to the angle of the jaw.

A child with a large RETRO-PERITONEAL DERMOID TUMOUR OR TERATOMA was brought forward by Mr. RAYMOND JOHNSON. The tumour was in the upper left half of the abdomen, and resembled a sarcoma of the kidney. The lumbar spine was curved to the right, and in the left loin were two small fluctuating swellings apparently not connected with the abdominal tumour. A portion of a small cyst was removed and showed the naked eye and microscopic appearances of a dermoid.

Dr. POYNTON showed a girl, æt. 7, with œdema of the left lower extremity and labium.

Three cases of INFANTILE PARALYSIS were shown by Dr. GEORGE CARPENTER. One of them was a boy, æt. 11, with double foot drop of sudden onset; the muscles of the front of the legs gave the R.D. reaction.

Another case was in a girl æt. 3, who suddenly became paraplegic. The muscles of the legs and thighs gave the R.D. reaction. The child also could not raise the head or hold it erect, but she could move it from side to side.

The third case was in a girl, æt. 20 months, whose right leg was paralysed and the muscles gave the R.D. reaction. The left leg was rigid and its muscles reacted to Faradism, though feebly. The onset was sudden, after an attack of diarrhœa and vomiting.

SYPHILITIC NEPHRITIS in an infant æt. 3 months was shown by Dr. CARPENTER. The child was dropsical, the urine albuminous, and contained blood corpuscles and hyaline epithelial and granular cysts. The infant was well nourished, but had chronic snuffles, with nasal mucopurulent discharge and a fading eruption on the buttocks, backs of thighs and calves. It had improved by mercurial treatment.

The cases were discussed by the Chairman, Drs. Poynton, Spriggs, Carpenter, Porter Parkinson, and Messrs. Raymond Johnson and Jaffrey.

THE Conference of representatives of Hospitals from various parts of the kingdom will take place at 2.30 p.m. on Thursday, December 6th, at University College, London.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

MEETING AT SHEFFIELD ON FRIDAY, NOVEMBER 16TH, 1906.

MR. R. FAVELL (Sheffield), President, in the Chair.

FIBROIDS AND PREGNANCY.

MR. FAVELL showed a seven months' pregnant uterus containing fœtus and placenta with a fibroid which had completely blocked the pelvis. The abdomen was opened during labour and after the fibroid had been enucleated it was found necessary to complete the operation by supra-vaginal hysterectomy.

Dr. H. BRIGGS (Liverpool) showed a fibroid enucleated from the front wall of the uterus when four and a half months pregnant. The bleeding could not be controlled until the uterus had been emptied through an incision in the tumour bed, after which sutures were effective.

Dr. BRIGGS also showed a large fibroid removed at the third month of pregnancy from the anterior wall of the uterus. In this case bleeding was easily controlled and pregnancy was not interrupted by the operation.

ECTOPIC GESTATION.

Dr. H. BRIGGS showed an ectopic gestation removed six weeks after full term. The sac was dissected off the rectum and two inches of ureter had to be freed from it, and great care was demanded in the subsequent peritonisation of the pelvic floor and viscera. Recovery was good.

Dr. MACGREGOR SINCLAIR (Burnley) showed three specimens of early tubal pregnancy.

CARCINOMA OF OVARY AND UTERUS.

Dr. W. K. WALLS (Manchester) mentioned a case in which a large solid tumour of the right ovary was removed. This proved to be a carcinoma, and metrostaxis continued. The abdomen was therefore reopened, the uterus was removed, and its body was found to contain a carcinomatous growth.

CÆSARIAN SECTION FOR OSTEOMALACIA.

Dr. P. BARBER (Sheffield) demonstrated a patient, æt. 36, 4 feet 6 inches in height, who had had seven pregnancies. Her history and measurements were typical of osteomalacia, though a woman of English race who had never suffered privation. The seventh pregnancy was successfully ended by Cæsarian section. Both ovaries were removed, and the patient's health has much improved since the operation.

HELIOTOMY.

Dr. A. J. WALLACE (Liverpool) described two cases of pelvic contraction in which the Cæsarian section was contra-indicated, and in which he had therefore divided the pubic bone to the left of the pubic symphysis. The children were both delivered alive with forceps. Considerable separation of the bones was observed. There was severe bleeding in the first case, and extraction was troublesome in the second, the cut end of the bone wounding the vaginal wall. Dr. Wallace was not favourably impressed with the operation, though recovery was satisfactory in each case.

Dr. A. W. W. LEA (Manchester) gave an interesting account of the work of the Section of Obstetrics at the Canadian Meeting of the British Medical Association.

Mr. FAVELL, the President, subsequently entertained a large number of members and friends at dinner. He was supported by Sir W. J. Sinclair and Dr. D. Lloyd Roberts. The latter, in proposing the health of the host, expressed the affection with which the President is regarded, while Mr. Favell's reply was most happily worded, and was received with enthusiasm.

LARYNGOLOGICAL SOCIETY OF LONDON.

MEETING HELD NOVEMBER 2ND, 1906,

The President, Dr. J. B. BALL in the Chair.

The following cases were shown:—

THE PRESIDENT.—A case of Tumour of the Pharynx of about the size of a tangerine orange, pushing forwards

the soft palate. The tumour was of solid consistence; on the external surface, just behind the ramus of the lower jaw, there was a distinct hard swelling, apparently continuous with the tumour inside. The patient had no pain and only a little difficulty in swallowing food, and occasionally slight difficulty with her breathing.

MR. BUTLIN considered the case was operable, and advised that the tumour be removed.

THE PRESIDENT also showed a man æt. 52, with a swelling over the left arytenoid region extending upwards along the ary-epiglottic fold, the lateral folds of the pharynx were also thickened.

DR. JOBSON HORNE cited a case which presented similar clinical appearances in the larynx, and which succumbed to chronic interstitial nephritis; at the post-mortem examination there was found below the swelling of the arytenoid and situated in the fold between the cartilages of Santorini and Wrisberg a minute ulcer leading down to commencing necrosis of the underlying cartilage.

DR. ST. CLAIR THOMSON shewed two cases of Extensive Tuberculous Laryngitis which had completely healed, and had remained healed for some time, without any local treatment. It was, moreover, noteworthy that neither of the cases had undergone treatment in a sanatorium. In the discussion which followed there was a general consensus of opinion, and several cases were cited, that good and similar results were obtained by rest without any local interference with the larynx.

DR. H. J. DAVIS shewed a case of Stenosis of the Glottis, with Dyspnœa and Stridor, with a history of four previous attacks of pleurisy and of physical signs in the left lung. The evidence was considered to be in favour of tuberculosis.

DR. WATSON WILLIAMS shewed a case of Epithelioma of the Larynx. Dr. ST. CLAIR THOMSON also one of Malignant Disease of the Larynx, and Dr. DUNDAS GRANT a Glosso-Epiglottic Growth believed to be Sarcoma. These three cases were discussed together; the disease was in all three cases at the base of the tongue and upper part of the larnyx. In two of them the glands were involved, but probably within the reach of an extensive operation.

MR. BUTLIN was of opinion that an operation should be performed in all three cases. It should comprise removal of the contents of the anterior triangle on the affected side, of ligature and removal of the external carotid artery and all its branches. It would be well to remove at the same time the external carotid artery and its branches on the other side of the neck. A few days later the removal of the primary disease could be performed with scarcely any hæmorrhage and as freely as might be desired.

THERAPEUTICAL SOCIETY.

MEETING HELD NOV. 20TH, AT THE APOTHECARIES' HALL, LONDON.

The President, Dr. T. E. BURTON BROWN, in the Chair.

The following papers were read:—

Dr. CECIL WALL:

"THE VALUE OF CERTAIN DRUGS IN THE TREATMENT OF CHOREA."

The author remarked that several hundreds of cases of chorea had been treated systematically, both as in and out-patients, at the London Hospital; one group had had no special drugs; another had had arsenic; another, sodium salicylate; and a fourth group, aceto-salicylic acid (aspirin). The effects of the different kinds of treatment were compared, the criterion being the number of weeks before the choreic movements ceased. The figures were very striking, and showed clearly that under arsenic the course of the chorea was practically the same as without any drugs at all; with sodium salicylate the results were little better; whilst with aceto-salicylic acid the shortening of the attack was very remarkable: in half the cases the movements ceased in less than one month. In 92 per cent. of the cases in less than two months; whereas with arsenic the movements went on for over two months in 62 per cent. of the cases. There had been no ill-results at all.

Dr. GRAY DUNCANSON laid stress on the excellent results afforded by arsenic in chorea in the North of England, and thought the absence of similar results in the South must depend upon some difference either in the chorea, or more likely in the temperaments of the children affected.

Drs. Burton Brown, Parker Douglas, and Herbert French also joined in the discussion.

Dr. A. F. HERTZ read a paper on the

"IMPORTANCE OF SALT-FREE DIET IN THE TREATMENT OF ŒDEMA AND SEROUS EFFUSIONS."

This communication embodied so much work, and such important deductions, that it is impossible to do it justice in a short abstract. The orginal paper must be consulted when it is published in due course.

Drs. Parker Douglas and Dickinson joined in the discussion.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Nov. 25th, 1906

AT the meeting of the Société Internationale de la Tuberculose held last week under the presidency of Prof. Lancereaux, the subject of

COMPULSORY NOTIFICATION OF TUBERCULOSIS

was brought forward by Drs. Samuel Bernheim and Louis Dieupart. The authors, after having referred to the conclusions of the recent International Conference on tuberculosis (at the Hague, in October, 1906) and the favourable report of the committee of the Academy of Medicine (June, 1906) declare: "That prophylaxy cannot become real and efficacious unless the compulsory notification of tuberculosis is legally enforced. In a struggle with such a formidable enemy, no half measures will avail. The compulsory notification of tuberculosis could be made without any shock to humanity. Certain countries have adopted it, and find the advantage of it. We must await the day when the public in all countries will be sufficiently educated to accept this excellent measure of protection unhesitatingly. Compulsory notification, of course, involves, *ipso facto*, compulsory disinfection. According to Messrs. Bernheim and Dieupart, compulsory notification during the lifetime of the patients should only apply to manifest tuberculosis in which the patient expectorates the bacilli. It appears to them needless to complicate the matter by including all forms of osseous ganglionic. cutaneous, and other forms which rarely present any danger.

At the same meeting, the

PHOSPHO-CREOSOTE TREATMENT OF TUBERCULOSIS

was introduced by Dr. Samuel Bernheim. He remarked that demineralisation is a characteristic of the tuberculous subject. The soil is poor in phosphates and chlorides. This tuberculous soil is a hypo-acid and a hyper-comburant. The best treatment consists in transforming this soil and in assimilating it, as far as possible, to the arthritic formula. The hygieno-dietetic treatment does this admirably. But this treatment is peculiarly facilitated, and its duration may even be abbreviated, if accompanied by certain medical treatment, especially phospho-creosote therapeutics. There is a poly-ether of creosote which facilitates this transformation of the tuberculous hypo-acid soil into arthritic hyper-acid soil, and this is phosphite of creosote of "Phosphotal" This salt acts both by its phosphoros acid, in removing the humoral acidity, by its phosphoric element, in combating the de-phosphorisation of the tuberculous soil and in replacing it by an arthritic soil, and finally by its

creosote, an acidifying medicament which liquefies the expectoration and especially influences the bacteria associated with the bacillus, which will decrease, and often disappear.

The author has treated a large number of tuberculous subjects with Phosphotal, and he particularly notes 97 cases most of which have derived benefit from this treatment. Phosphotal, which is easily tolerated, is administered *per os*, by subcutaneous injections, or by the rectum, in daily doses of 0.50 centigrammes to 2 grammes. This treatment may be continued for a very long period without the slightest inconvenience; an interval of eight days should be allowed after administering Phosphotal for three weeks.

Pneumonia.

According to M. Musciangoli, sulphide or carbon possesses real efficacy in the treatment of acute pneumonia. A purgative is at first administered, and the following day he gives a tablespoonful every hour of:—

Sulphide of Carbon .. .. 1 drachm.
Peppermint water .. .. 4 ounces.

Four children treated thus by the author were cured in from one to three days.

Pleurisy and Pilocarpine.

A doctor relates that, called to a patient suffeeing from a large effusion into the pleura, thoracocentesis was advised but the patient refused it from pusillanimity, and injections of pilocarpine were substituted with complete success. The dose employed was one-fifth of a grain. and the injections repeated every day for a week, at the end of which time the effusion had disappeared.

GERMANY.

Berlin, Nov. 25th, 1906

At the meeting of the Medical Society Dr. Rothschild showed a young man æt. 21, who for some weeks before had persistent and severe pains in the perinæum and base of the penis, which had reduced him to a very low condition, and there was also persistent dribbling of urine. The urine contained pus and blood, and there was also some blood from the anus. A Nelaton catheter passed quite easily. The bladder would not hold more than 30 cm. (1 oz.) of fluid. Under treatment with narcotics and washing out of the bladder, the urine gradually cleared and the capacity of the bladder increased, but the pains still continued and some blood still came now and then from the perinæum. At this period the patient, who had been repeatedly questioned, stated that some time previously he had passed a tube containing wax into his urethra. When the tube was withdraw the wax remained. Röntgen illumination now showed concrements. Sectio alta was performed, the calculus removed, and the bladder closed by suture. The result was good.

Exz. v. Bergmann reported shortly the case of a patient suffering from

Stricture of the Urethra

with retention of urine. After gradual dilatation of the stricture a stone was accidentally felt, the origin of which was paraffine that had got into the bladder. In Brussels a woman had tried to relieve the stricture by injecting paraffine.

Hr. Cryilletzer related a case of

Widespread Injuries through the Electric Current.

In a factory very strong currents were employed, in which the very strong iron parts inserted in current circle were cut through by a very intense and hot arc light from carbon points. This work was carried on in the open in a corner of the workyard. Five yards away from this was the path leading to the closets. Of the workpeople who had passed along the path, not as engaged at the work in question, but merely passing to and from the closets, twelve were taken ill the following night with violent pains in the eyes. All twelve came the following morning to the speaker, and all complaining of the same troubles. All had intense pain, photophobia, swelling of the conjunctiva and of the eyelids. One of them had slight clouding of the cornea. The refracting media were intact, and there was slight reddening at the fundus. The cases were well-marked ones of ophthalmia electrica. In a few days the trouble disappeared. From these occurrences it behoved to take precautions at such works to protect not only those who worked at them, but others who only had to pass near them.

It was not the heat rays that had caused the ophthalmia; the workmen working at the job in question were not affected, but only those who passed by at some little distance away. It must have been the ultra-violet rays, and in favour of this assumption was the absence of after-images, of which not one made any mention.

Hr. Hirschberg was of opinion that all rays might be injurious to the eyes, and care should be taken to protect them in all dangerous occupations.

Hr. Oppenheim showed a case of

Occipital Tumour of the Brain Cured by Operation.

A merchant, æt. 35, was taken ill in March last with pains in the head, especially the back of it, the neck and back. When seen on April 25th an examination of the nerve system showed nothing. On May 8th there was hæmorrhage into the retina of the left side, some days later optic neuritis of the same side, and distinct slowing of the pulse. Then came on vomiting, bilateral choked disc, hemianopsia of the left side, and visual hallucinations, as well as alexy and agraphy. The speaker made a diagnosis of tumour of the posterior lobe of the brain, and as mercury and iodide did no good, he at once decided to operate. The operation was performed by F. Krause, who found a tumour in the posterior part of the posterior lobe that could be shelled out. At first the optic hallucinations got worse after the operation, but they soon became fainter, and gradually all the symptoms disappeared, the hemianopsia as well, so that complete recovery took place.

Hr. Krause said that the tumour, a spindle-celled sarcoma, was an encapsuled one the size of a pigeon's egg. It lay near the mid line in the left posterior lobe, and extended to the cuneus. It was shelled out without any hæmorrhage. After the operation there was high temperature, but this did not mean fever, but was only a result of the operation in the immediate neighbourhood of the medulla oblongata. Recovery was uninterrupted.

Health Statistics in Prussia for 1904.

This report has just mads its appearance. It is compiled in the department of the Mimister for Spiritual, Medical and Educational Affairs, and published by R. Schoetz. The number of births for the year was the highest ever known, and reached a total of 1,304,697, showing an increase of 30,031, of which 29,321 were living children. The proportionate rate of birth was 35.04 per 1,000. This is below the figure, for 1901 and 1902, but a little better than 1903. The absolute number of deaths was 702,147, 5,803 less than the previous year. The death-rate per 1,000 inhabitants was 19.46, whilst the death-rate for 1903 was 19.9. The worst figures come from Silesia, with a death-rate of 24·16 per 1,000, and the most favourable from Schleswig-Holstein, 15.97 per 1,000. One-third of all the deaths were in infants under one year of age.

The Treatment of Nasal Catarrh.

The *Deutsche Med. Zeitung*, No. 85, contains a reference to the subject from the pen of Dr. Zäslein. It is well known that a nasal catarrh often leads to mischief elsewhere, and that many cases of bronchitis linger on for weeks for the reason that a nasal catarrh continues to furnish ever fresh infective material. It is desirable, therefore, to treat the nasal cavity as energetically as possible. The methods hitherto employed, such a douches and snuffing powders, are very little or no good, as the nasal mucous surfaces cannot bear powerful antiseptics. Incomparably better results have followed the use of solutions of

collargol, ½ to 1 per cent. solutions applied 6 to 8 times a day to all three nasal canals of both sides, blown in by a pulverisator. If the circulation in the nose is impeded by scabs or swelling of the mucous membrane, cocaine and menthol nasal powders should be made use of before applying the collargol. In this way the secretion dries up rapidly. If there is angina as well, gargles with a 2 per cent. solution of collargol may be made use of.

THE TREATMENT OF RECENT WOUNDS BY DRYING.

The *Munch. med. Wochensch.*, 42, 1906, contains a paper on this subject by Dr. Asbeck. The author, who is a naval surgeon, was in the habit of placing the freshly-wounded in the hot sun on the deck, and in this way got his dressings dried rapidly in the tropical heat. The wounds healed without suppuration or change of dressing in a few days. On days when there was no sun he dried them by the heat of the boilers.

Every recent injury was, without disinfection of the surrounding parts or being touched with the hand, covered with an iodoform gauze compress, kept in place by a few layers of gauze. Over this cotton-wool was placed (lint or gamgee), and the whole fixed with a gauze bandage. In the case of burns the blisters were removed with scissors and forceps, and the part covered with iodoform gauze. Of course the greatest care was observed as regards asepsis.

The wounded so dressed were now subjected to the glowing heat of the boiler for from a half to three-quarters of an hour, whereby an "intensive" drying was achieved. If the covering got wet with later hæmorrhage from the wound, a new layer of gauze was simply put on and dried as before. In these cases also healing took place in a few days.

This method was tried in about 500 recent injuries and with satisfactory results. For drying-up he used whatever heat was handiest—furnace boilers, the smith's fire, the Bunsen burner. Later he used xeroform gauze in place of iodoform, and when removing this a 2 per cent. perhydrol (Merck) was used. Eleven gunshot wounds treated in the same way healed without suppuration.

AUSTRIA.

Vienna, Nov. 25th 1906.

SYPHILIS IN THE CRANIUM.

EHRMANN presented a case of excessive tertiary syphilis. The whole scalp was raised up from the periosteum by an enormous infiltration. Its progress was serpiginous, with a garland appearance at the base of a brown infiltrate, showing that it was not scrofulous but gummatous in nature, having all the appearance of an untreated tertiary case.

Lang thought these cases mostly ran a very favourable course, although great destruction was often done before they healed. He had a female with the whole scalp lifted, and an opening in the calvaria about the size of the palm of the hand that had been eaten away through the lamina vitrea to the dura mater, so that the pulsation of the brain could be easily perceived. To protect the soft substance from protruding, an aluminium plate was applied with excellent results.

Marack thought Erhmann's case now required strong prophylactic treatment.

APPENDICITIS AND EXTRA-UTERINE PREGNANCY.

Fabricius showed a few preparations where extra-uterine pregnancy had been diagnosed for appendicitis and *vice versa*. Along with these complications, a myoma in the right iliac fossa added to the difficulty. In another case of extra-uterine pregnancy he found the gravid tube adherent in the pouch of Douglas flattened and immovably fixed. In another case he met with a six weeks' pregnancy in a severe case of appendicitis. In this case the fœtus was pressed quite flat and scarcely recognisable in the diagnosis. The importance of the latter case lies in the danger of the ovum bursting and doing fatal injury.

INTERNAL CHRONIC IDIOPATHIC HYDROCEPHALUS.

Fuchs demonstrated a case of interesting hydrocephalus in a child. His examination of the eyes showed that both papillæ were greatly congested, and far advanced in atrophy. There was also distinct exophthalmia present, but all the reflex organs were healthy. The nerve system was apparently healthy, with the exception of a blowing sound in the head, which was objective. To ascertain with accuracy the otoscope was used, and found the blowing greater on the right side than the left. This blowing sound synchronised with the systole, which could be modified or destroyed by compressing one or both carotids.

Was this a tumour or aneurysm of the brain? The relative youth of the patient was against this hypothesis. The congested papillæ was also a negative sign, as this rarely occurs in endocranial aneurysms. His own opinion was that this was a case of hydrocephalus idiopathicus chronicus internus of the adult, which is slow and intermitting in its progress. The intermitting blowing sound in the head was another confirmatory factor in the case.

Frey thought that our present knowledge received very little assistance in the diagnosis from this objective rushing sound.

Schlesinger thought the youth of the patient was no argument against the presence of aneurysm. This affection is relatively more common in youth than in the adult, and therefore a strong proof of the affection being an aneurysm.

CEREBRAL TUMOUR.

Flesch showed a preparation taken from the *post-mortem* room that confirmed the diagnosis. The growth extended from the sphenoid bone along the left side of the head to the middle of the occipital.

PSEUDO-MENIERE.

Frankl-Hochwart showed a patient with vertigo resembling that met with in Meniere's disease. These attacks occurred daily, or at least several times a week. Immediately before the attack, and sometimes during the attack, a loud rushing noise is experienced in both ears. During the invasion all went round, sometimes to the right, sometimes to the left; he could either stand or sit, and never lay down; neither did he close the eyes. Morbus Basedowii was present in a slight degree, but the most interesting point was that exacerbation of the ear and vomiting during the attacks had all the symptoms of Meniere disease. Against genuine vertigo auralis is the negative condition of the ears and the circumstance that the patient can stand upright and also not close the eyes. Hochwart considered it one of pseudo-Meniere.

GANGRENA PEDIS.

Schwarz referred to Moszkowicz's intermitting halt as a prodroma of gangrene. He was disinclined to accept this opinion in the early stage of the disease, as any insufficiency of the artery such as sclerosis of the wall of the vessel when the muscle is exercised will produce severe spasm just in the same way that angina pectoris is produced when the coronary arteries of the heart have become sclerotic. In such cases Moszkowicz's symptom would be misleading.

Moszkowicz admitted the confusion that might arise in the diagnosis if intermitting lameness was accepted as pathogenic. The point he wished to demonstrate was the hyperæmia after the binding and freeing of the extremity. The intermitting lameness appears in some cases, but not in all.

HUNGARY.

Budapest, Nov. 25th, 1906.

AT the recent meeting of the Royal Hungarian Medical Society, Dr. Altmann exhibited a man, æt. 60, with

MULTIPLE LIPOMATA OF THE NECK.

The patient first noticed these tumours nine years ago. At first they annoyed him on account of the pressure which they made upon his collar button. The tumours at that time were about the size of a pea, but within a year or so they had attained their present size. The patient had not found it necessary, however, to wear a collar of larger size on account of the tumours. At the time of the incision, there was no attempt made

to remove the entire tumours, but only portions of them were taken away. This operation was done by another surgeon. The tumours had been practically stationary in size for five years. Dr. Altmann stated that symmetrical lipomata of the neck region were not very rare, but that this was a pronounced case. Patient had large lipomata in front of the neck, which, he said, was not an unusual concomitant of such cases.

Dr. Aczél read a paper on

HYPODERMOCLYSIS IN PNEUMONIA.

In spite of all the innovations which have been made in the treatment of pneumonia, the death rate has been very little changed during the past three or four decades. Statistics, however, in such a disease as pneumonia, in which so much depends upon the age, the previous habits and condition of the patient, and the "genus epidemicus," are not only not infallible, but often misleading. Dr. Aczél applies hypodermoclysis, as recommended by Henry, in such cases. He believes that hypodermoclysis is theoretically indicated in every case of pneumonia, although he does not employ it in many mild cases. It dilutes toxins and favours their elimination; it preserves the alkalinity of the blood, which is one of the most important properties of the vital fluid, and, finally, certainly tends to prevent the formation of heart clot, which the writer believes to be a frequent cause of death in pneumonia. The solution employed contains 2.50 grammes sodium chloride to the pint of distilled and sterilised water. He uses a large syringe or chest aspirator, the action being reversed, and injects from 3—4 litres once a day.

Dr. Veress spoke about the Toxic Agent of Cholæmia. Icteric patients sometimes develop an alarming series of cerebral symptoms which usually end in coma and death. The direct cause has frequently been a matter of speculation, and it is as yet undecided whether the bile pigments, bile acids, or the loss of hepatic function are at fault. Dr. Veress noticed a close resemblance to diabetic coma, and concluded that the whole condition is an acid intoxication. The common bile-duct was ligated in a number of rabbits and the blood titrated every day until death, which generally occurred on the fifth or sixth day. The alkalinity gradually diminished day by day, but not to a sufficient degree to account for the symptoms on the basis of an acid intoxication. The amount of carbon dioxide was also found considerably below normal. Since animals with much less alkali have been known to live for days, probably other facts bring on the fatal issue.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

THE GENERAL MEDICAL COUNCIL ELECTION.

DR. BRUCE has issued an address to the practitioners of Scotland, of which the following are his leading points:—After alluding to the fact that for twenty years he has endeavoured to discharge the duties of his position as direct representative for Scotland to the satisfaction of his constituents, and with a single eye to the interest of the medical public, is strongly of opinion that the profession is not fully enough represented at present in the Council, and his first efforts, if re-elected, will be directed to induce the Council to enlarge the present number of representatives selected directly. Failing to get the Council to take up the duty, he proposes, along with his English and Irish colleagues in the direct representation, to petition the Privy Council to solve the difficulty. As regards medical education and training, he holds strongly that there should be more practical and clinical work than there is now. In particular, he says, the great department of midwifery is not taught as it should be. Clinical attendance at a lying-in hospital ought to be compulsory. The present medical curriculum much requires to be lightened in its first stages by relegating botany, physics, and biology to a *preliminary* science examination. In this way more time could be devoted to general clinical work, as also to special subjects, such as psychology, eye, ear, throat, and skin diseases He would also assist in any effort dealing with the sale of patent medicines, in reform of hospital abuse, and in maintaining the reputation of the profession by discountenancing, so far as the Council can, contract medical practice.

Considerably more interest is being taken in this than in the last election of a direct representative. Dr. Walker has addressed several meetings in various towns in support of his candidature, and has issued, as an election address, a report of his first speech in Edinburgh, to which we have already fully referred. Some attempts have been made to make it seem as though by the return of Dr. Walker, Edinburgh would be unduly favoured in the matter of representation on the Council, as compared with Glasgow. This is surely merely playing upon the local jealousy which, unfortunately, still exists between the two cities. If Dr. Walker is elected his Glasgow constituents need not fear that he will in any way subordinate their interests to those nearer his home, nor in any way neglect them.

AN IMPORTANT VACANCY AT THE GLASGOW ROYAL INFIRMARY.

The directors of the Glasgow Royal Infirmary are at present advertising for a physician to take charge of the wards vacated by Dr. John Lindsay Steven, who, it will be remembered, was transferred to the Western Infirmary to succeed the late Dr. James Finlayson. Candidates for the appointment must have been registered practitioners of ten years' standing. We understand that Dr. Hugh McLaren and Dr. Mackenzie Anderson, both of whom have been assistant physicians, are applicants. Dr. McLaren is conducting the work in the wards at present, and has had considerable experience of pathological work. At present he is the Professor of Materia Medica and Therapeutics at Anderson's College of Medicine.

LETTERS TO THE EDITOR.

THE GENERAL MEDICAL COUNCIL ELECTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The quiet, contemplative and reasonable letter of Dr. Crichton, which you published on the 14th inst., is somewhat contagious, and one feels tempted to review this election contest in somewhat the same manner. There certainly seems to be more excitement this time than previously; whether it will result in a larger poll remains to be seen. Those who see only the *British Medical Journal* would naturally expect that its candidates will carry all before them. But the ground covered by that journal does not embrace the whole medical world, and well is it that this is so, inasmuch as it appears to become more cliqué and narrow-minded as time progresses. I shall be glad, therefore, if you will permit me as an elector to take a dispassionate view of the candidates and their claims to support.

Beginning with the two existing members of the General Medical Council, Messrs. Brown and Jackson, it is, of course, uncertain whether they will retain their seats, so many changes having taken place since their election five years ago. There has been the new constitution formed of the British Medical Association, which is responsible for much of the hubbub now going on; hence a calm review of the situation is essential on the eve of the election. Even your correspondent Dr. Crichton does not recognise that there are any burning questions at issue between the candidates, and doubtless there are many others who view the matter in the same light.

To my mind the main question is contract practice, as applied to provident dispensaries and clubs. This is and has been a growing evil for many years, and is sapping the very life-blood out of our daily life. Its

ramifications are enormous. A decent man may commence practice in many places, and sedulously follow out the best traditions of the profession; yet he will remain months and months without patients. And why? Because the place is honeycombed with clubs and dispensaries.

And I am sorry to say the British Medical Association itself is infected, and very largely, with this evil. Many, if not most, of the active men at headquarters are pushing it for all they are worth, through a public medical service, which will mean more riddling, more honeycombing of general practice, and with all the sanction and *éclat* of that great association.

The question naturally follows—what, then, are we to do as electors? According to my opinion, there is one candidate who seems specially fitted for this task, and that is, Dr. G. H. Broadbent, of Manchester, who has had, as we read in his address, special training for this work. Years ago he was on the staff of a dispensary, and fought for a wage limit, and when he could not get it, he left that institution, and is still fighting for this point. He is the candidate for whom I shall vote, and I trust thousands of others will view this election from my standpoint. But the great danger is the apathy of the electors at large, especially of those who are not members of the British Medical Association. If all will record their votes as soon as they receive the ballot paper, this election will at least show that the profession has arisen to the full discharge of its duties when a great occasion demands.

I am, Sir, yours truly,

AN ELECTOR.

Manchester, November 24th, 1906.

*** On account of the extreme length of our correspondent's letter, we have been compelled to reduce it very considerably.—ED. "M. P. and C."

THE CANDIDATURE OF MR. J. RUTHERFORD MORISON.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—By this time the practitioners who take any interest in this election must be pretty well posted up in the merits of the respective candidates. We do not propose, therefore, to do more in this last word on Mr. Morison's behalf than to answer the only objection—if, indeed, it can be dignified by that name—to his candidature. He is accused in some quarters of being a consultant, and to this he must plead guilty. To the general practitioners of the North, who know Mr. Morison best and have deliberately chosen him on this as on many other occasions to be their representative, the fact of his being a consultant, with his previous record of 13 years in general practice and his work for us since he became a consultant, seems to give him a peculiar claim on the support of the profession, as he is enabled to look at all medical questions from both sides. We know where his sympathies lie, and with the record of Sir Victor Horsley before us, we are not to be made ashamed of our candidate because he does not now happen to be in general practice.

We would earnestly appeal to the profession to distribute their votes, other things being equal, with some reference to the geographical distribution of the candidates. The medical men in this part of the country have pretty generally made up their minds to vote for Messrs. Morison, Browne, and MacManus on the grounds that these gentlemen are thoroughly good candidates and represent broadly the North, Midlands, and South. We appeal finally for such a vote, however distributed, as will once for all end the cry that medical men take no interest in their own business.

We are, Sir, yours faithfully,

E. JEPSON, Chairman.
ALFRED COX,
H. HUNTER,
Honorary Secretaries to Mr. Morison's Committee.

Cotfield House, Gateshead, November 19th, 1906.

THE DECLINING BIRTH-RATE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It is impossible to exaggerate the importance of this subject; and if you and your readers are not for the moment tired of it, you may care to note the last phase of the question in France. French statistics for 1905 show that whilst marriages increased comparatively, births fell off, the rate being the lowest on record. In forty-four departments—as compared with thirty-six in the previous year—the deaths were in excess of the births; and in certain provinces the difference was enormous—three deaths as against two births. It must be borne in mind that the population has remained stationary since 1871, although every intelligent Frenchman has known that their national safety has depended all along upon due increase of numbers. Prudence, which may at first have formed a plausible excuse for restricting the number of children, has universally deteriorated into a narrow form of selfishness, unmoved even by the call of patriotism.

It would require an essay to examine the effects upon parents and offspring, among those classes able to support a larger family, where the number of children is restricted to two or three, but these effects are to be learnt from a study of contemporary French literature, and unquestionably suggest extensive progressive decadence. There may, of course, be grounds for controversy in this direction, but there can be no dispute about the main fact that, viewed from the international point of view, the French are committing deliberate race suicide, or, as it is now styled, more appropriately, *felo de se*. It would be interesting to learn from Dr. Drysdale and his fellow-protagonists of the cult of neo-Malthusianism, what grounds they have for the belief that the British people will show more restraint than their neighbours, and will think more of the preservation of their country, and the creation of a truly mighty empire than of their own narrow egotistical desires. Is it not certain that in imitating the French we have entered upon a slippery path which, unless the soul of the nation can be speedily roused, will land us in the abyss towards which our neighbours have already far progressed, and seem now inevitably bound.

I am, Sir, yours truly,

AN OBSCURE PRACTITIONER.

November 23rd, 1906.

PROSPECTS OF MEDICAL LAW REFORM.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The editor of the *British Medical Journal* gravely rebukes a correspondent for his ignorance of the fact that the Association has been engaged in drafting a new Medical Act. It is one thing to draw up a project of law quite satisfactory to experts outside Parliament; quite another thing to get the project accepted by the Legislature. It is easy to "call spirits from the vasty deep; but will they answer when you call on them?" Does anyone believe that the present Government is in the least likely to take up, and endeavour to pass a Medical Act satisfactory to the profession? Does anyone acquainted with the legislative machinery of the present day, and informed as to the attitude of individual members, and the House of Commons as a whole, towards the profession, believe that a new Medical Bill would have the remotest chance of serious attention if introduced by a private member, however distinguished, without the support of the Cabinet? Does anyone acquainted with the glaring facts of the case doubt that introduction of a new Act by a medical member would suffice to ensure a hostile reception, and opposition more than sufficient to wreck it? Medical sponsorship would inflame the ardour of all those who distrust the profession, of those who dislike it, and of those who associate it with the practices of vaccination and vivisection to combat which they devote their lives. The suggestion of selfish trade's union motives would be impossible to refute. The case for legislation cannot be made unanswerable until irrefragable proof has been afforded by means of a public enquiry

that amendment of the law is called for more for the protection of the public than the advantage of the profession, and the sooner this fact is recognised and acted upon by the British Medical Association the better it will be for the cause of reform.

I am, Sir, yours truly, S.

November 23rd, 1906.

OVERDOSAGE WITH TRIONAL.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Noticing an editorial in your issue of September 26th on "Overdosage with Trional," I thought that a case which came to my knowledge in July, 1901, might be of interest.

The patient, a female, æt. 33, was at a seaside resort for her health, attended by a trained nurse. For several years she had been treated for various phases of nervous disorder, which frequently bordered upon melancholia. Trional had been prescribed for the persistent insomnia, in powders of grs. xxx., and she always carried a supply. Upon this occasion, wishing to put an end to her existence, she took ten of the 30-grain powders, very cunningly chewing up and swallowing all the papers but two, and these she threw into the wastepaper basket. The nurse coming up to see her some time later found her in a condition of stupor, and finding but two powders left in the box which had contained a dozen, grasped the situation at once, in spite of the two decoy papers in the basket. On my arrival the patient had stertorous breathing, well-marked cyanosis, pulse soft, weak, and slow, and she could just be aroused enough to swallow. Whiskey had already been given, and an emetic of Zn. Sulph. was very effectual; strong coffee was given and eventually retained. As the patient had an idiosyncrasy for strychnine, this was withheld, and aromatic ammonia and caffein citrate given instead. The pulse picked up rapidly, and in twenty-four hours most of the toxic symptoms disappeared, and the patient had so far returned to her normal condition as to express regret for her action, and explain why she had swallowed the powder papers.

The treatment may be criticised; but when on a holiday trip one has to take what is nearest to hand in an emergency, and the result could hardly have been improved upon.

I am, Sir, yours truly,

MALCOLM MACKAY.

Windsor Mills, Canada, Nov. 19th, 1906.

ANTI-VIVISECTION METHODS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—May I assure your correspondent "Physiologist" that all responsible Anti-vivisectionists deeply deplore the inaccurate and ridiculous statement which appeared—they know not how—in *The Tribune* about a cat jumping off the table in the course of vivisection by Professor Starling. This is a story which any Anti-vivisectionist who knows the conditions under which Vivisection is carried on would distrust from the simple fact that the details of the experiment referred to were supplied by Professor Starling himself, who was not likely to add such a sensational detail, even if it had been true. *The Tribune's* withdrawal was therefore not needed in our case to discredit the story. I can only suggest that it was either a practical joke carried out by some vivisectionist with a view to further developments, or the action of one of those irresponsible persons who unfortunately cannot be prevented from joining themselves to every public movement. It is certainly not a sample of the "Anti-vivisection methods" of the British Union, or, I think, of any other recognised Anti-vivisection Society.

I am, Sir, yours truly,

B. E. KIDD,

Secretary British Union for the Abolition of Vivisection,

32, Charing Cross, S.W.

OBITUARY.

GUSTAVE I. SCHORSTEIN, M.A., M.D., F.R.C.P.

LAST week we recorded the death of Dr. Schorstein, which occurred as the result of diabetes at the early age of forty-three. Dr. Schorstein had a brilliant career at Christ Church, Oxford, where he proved himself so accomplished a classical scholar that after graduation he was elected junior student and assistant tutor. Fond as he was of classics, however, his heart was set on medicine, and he left Oxford to study at the London Hospital. His keen intelligence and unusual energy there won for him the same distinction as he had gained at the University, and after qualifying and serving in junior posts, he was elected Assistant Physician. Soon afterwards he was appointed to a similar position in the Brompton Consumption Hospital, and at the time of his death he was full Physician to both institutions. To an enthusiasm amounting almost to a passion for his clinical work, Dr. Schorstein added rare personal qualities. His large-heartedness and overflowing good-nature made him immensely popular with everyone with whom he came in contact, and his tact never failed him even in dealing with the most dour hospital patient. Straightforward, honourable to a fault, and ever spreading happiness around him, Dr. Schorstein has left a place in the hearts of his friends and colleagues that can never quite be filled.

EDMUND SYMES THOMPSON, M.D., F.R.C.P. LOND.

WE regret to announce the death of Dr. Edmund Symes Thompson, on Saturday, at 33, Cavendish Square, London, at the age of 69. He was a son of the late Dr. Theophilus Thompson, F.R.S., an authority on pulmonary diseases. Dr. Thompson was educated at St Paul's School and King's College, and graduated as M.B. of the University of London in 1859, taking the University medical scholarship and gold medal. He took the degree of M.D. in 1860, became a member of the Royal College of Physicians in 1862, and was elected to the Fellowship of the college in 1868. He was appointed assistant physician to King's College Hospital and to the Consumption Hospital at Brompton, to which he was consulting physician at the time of his decease. He was also Gresham Professor of Medicine, and in that capacity delivered lectures for many years. Among his published works were "Observations on Influenza" and an edition of his father's Lectures on Pulmonary Consumption.

JOHN GREIG McDOWALL, M.D.EDIN

WE regret to note the death of Dr. John Greig McDowall, the medical superintendent of the West Riding Lunatic Asylum at Menston, of which institution he has been head ever since it was opened in 1888. Dr. McDowall died suddenly at the age of 55. A Scotsman by birth, he possessed rare tact and discretion, as well as considerable administrative nd organising ability. The asylum at Menston is the third of its kind in the West Riding, those at Wakefield and Wadsley (Sheffield) having been respectivelv completed in 1819 and 1874. Deceased was educated medically at the University of Edinburgh, where he took the M.B., C.M., in 1873, and the M.D. in 1883.

SPECIAL ARTICLE.

THE REPORT OF THE POOR-LAW REFORM COMMISSION (IRELAND).

THE first volume of the Report of the Viceregal Commission on Poor-law Reform in Ireland appeared at the end of October, and contains the text of the Report itself. Further volumes will consist of an "Appendix" and of "Minutes of Evidence and Index." The Commissioners, who were appointed by Lord Dudley in May, 1903, were Mr. W. L. Wicks, a member of the Local Government Board; Mr. George

Murnaghan, a Member of Parliament and chairman of a board of guardians; and Dr. Cory Bigger, one of the medical inspectors of the Local Government Board. Though they have spent over three years in their inquiries and deliberations, they certainly cannot be accused of having wasted any time. They inspected all the workhouses, county infirmaries, fever hospitals, and other hospitals in Ireland, maintained wholly or in part out of local rates. They visited and examined the circumstances of localities at a distance from any hospital, with a view of discovering whether further hospital accommodation is necessary. They examined 743 witnesses, and occupied 59 days in public sittings.

They have therefore made the most thorough investigation of the Poor-law system in Ireland which has been undertaken since its inauguration seventy years ago. Interpreting the terms of reference in the widest sense, the Commission has made recommendations, not of reform, but of revolution. There is no detail of the system too petty, no principle too great, for their investigation, and they have succeeded in formulating—whatever be its faults—a scheme at once comprehensive, rational, and thorough.

Our space forbids us following the Commissioners through their historical survey, or into the details of their study of every phase of Poor-law work. We can only touch on a few main points in their scheme of reform.

The workhouse system, as it has existed for two generations, should be entirely abolished. In order to make provision for the various classes of persons at present inmates of workhouses or workhouse hospitals, the following recommendations are made:—

1. The *sick* would be provided for in county or district hospitals. Sanatoria would be provided for the treatment of pulmonary tuberculosis.

2. The *aged and infirm* of a County or Counties would be placed and classified in the most conveniently situated disused workhouse, as a county or district "almshouse"; or boarded out in institutions such as those maintained by the Little Sisters of the Poor or the Sisters of Nazareth; or by the trustees of ordinary almshouses.

3. The *Insane* of all kinds in workhouses at present would be removed to lunatic asylums.

4. Two disused workhouses in Ireland might be set apart for the *sane epileptics*.

5. The *mothers of illegitimate children* should never be admitted or retained in any workhouse or institution where they would have freedom of ingress or egress, and where they could associate with other classes. Unmarried mothers should be provided for in special institutions under religious or philanthropic management, *their infants being kept with them until weaned*.

6. Nearly all *children* ought to be boarded out from (say) one year old up to whatever age it may be thought best to fix as a maximum limit of age for boys and girls respectively.

7. For *casuals and vagrants*, they recommend an institution (say *four* at first for all Ireland) to be called the "Labour-House," where, if they were found begging, or if they are dependent on the public for their support, they would be detained under order of a court of justice for long periods (say from one to three years), for the purpose of accustoming them to habits of sobriety, regularity, and industry.

8. As regards "*all other able-bodied*," they suggest that the really able-bodied loafing ne'er-do-well class be put with the casuals and vagrants.

The Commissioners believe that, apart from hospitals and asylums, only 63 buildings would be required for the above purposes. This includes an estimate of 12 sanatoria for consumptives. Obviously, no new buildings would be required, as there would be available a large number of disused workhouses.

The remarks on the present position of medical men in the Poor-law hospital service will attract attention, as will also the proposal to establish a State Medical Service. The witnesses referred to in support of the latter are Dr. Warnock, of Donegal, and Dr. Thompson, of Omagh. It is suggested that admission to the State Medical Service should be by competitive examination, on similar lines to the examinations for the Army, Navy, and Indian Medical Services. Admission should, however, be limited to candidates educated in Ireland. Control of the Service in all important matters should be in the hands of a Council of representative physicians and surgeons, nominated, for instance, by the professional colleges and the Universities. Pensions on the Civil Service scale should be the right of members of the State Medical Service. In this connection we quote one sentence:—

"One must acknowledge that at present there is not any motive except the very highest to encourage a medical officer in remote districts of the country to discharge his duties zealously and conscientiously, and in a manner worthy of the traditions, character, and obligations of the profession of medicine."

It is to be noted that the Commission regard the Dispensary Medical Service and Public Health Service as outside the scope of their inquiries, but their inclusion would facilitate the scheme.

The Report is unanimous, except as regards certain financial clauses, as to which Mr. Murnaghan differs from his colleagues.

LITERARY NOTES.

To medical men essentially it pertains to diffuse correct knowledge with regard to alcohol and its use in health. The views of the profession on the subject have undergone a radical and healthy change in the last quarter of a century, and there are already signs of a "wave of sobriety" coming over the nation. Those who wish to forward this movement can safely trust "The Alcohol Problem in its Biological Aspect," by Dr. Kelynack, a well-written, handy treatise for popular perusal.

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A capital little book on "Local Anæsthesia in General Surgery" has just been written by Mr. J. W. Struthers, of the Leith Hospital and Royal Infirmary, Edinburgh. The range of utility of local anæsthesia has been enormously increased of late years, and for minor surgery in general practice the convenience of dispensing with a general anæsthesia is great. The various methods of inducing anæsthetic by local applications and drugs are concisely set out in this work.

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Till lately Davos was held to offer one of the few chances open to the consumptive; but the home sanatorium must seriously have encroached on its popularity. Still, the climate and *entourage* of Davos have peculiar advantages for those who are well enough off to afford to winter there, and what these advantages are has been made the subject of a book. "Davos," by Dr. W. R. Huggard, and a staff of contributors. It should prove useful to medical men who have patients wishing to go there.

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THE second edition of that practical handbook, entitled "Woman's Health and How to Take Care of It," by Florence Stackpoole, has just been issued by Messrs. John Wright and Co., of Bristol. Written by a woman for women on proper lines, it will naturally appeal to those for whom it is specially intended; but junior practitioners will find within this volume many useful hints as to the management of some of those apparently puzzling cases which those beginning practice are sure to encounter.

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AN interesting little treatise has just been published by Messrs. Cassell and Co., Limited, entitled "The Health Reader," written by Miss Hoskyns-Abrahall. It deals in a popular way with matters affecting personal health. Among other interesting features are the illustrations of famous scientists, such as Lord Lister,

Pasteur, and Darwin. For use in schools this book is admirably adapted, and a knowledge of the principles which its authoress endeavours to teach will do much to make the homes of the people healthier and happier. It has our hearty commendation.

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MR. LOUIS RAWLING, F.R.C.S., of St. Bartholomew's, has brought out a neat little Atlas of the Superficial Muscles and Nerves. The plan adopted is that of displaying the photograph of a posed living subject on one page with a facsimile drawing delineating the muscles and nerves on the opposite one. There are in all four such pairs of illustrations. The idea is a happy one, and it is well carried out. Art students should find the Atlas of great assistance.

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WE have been asked to draw attention to the fact that Messrs. Alex. Thom and Co., Ltd., publishers of Thom's "Official Directory," are now preparing for publication an entirely new work, which they will also publish immediately, entitled "A Directory of the Manufacturers and Shippers of Ireland." There is in Ireland itself a strenuous and sustained movement for the promotion and development of the manufacturing industries of the country, and it is unquestionable that amongst Irishmen abroad, as well as in the United Kingdom, there is a generous desire to widen the markets for Irish products. The publishers have, we understand, secured the co-operation of Irish writers who are specially competent to contribute articles upon the economic conditions influencing the manufacturing industries and commerce of the country.

REVIEWS OF BOOKS.

MAY AND WORTH ON DISEASES OF THE EYE. (*a*)

THE popularity attained by former editions of May on Diseases of the Eye evidently induced the authors to produce a joint work, with the object of combining in one volume the best teaching of the American and British Schools of Ophthalmology. By so doing, without doubt they have succeeded in compiling a text-book on Diseases of the Eye which, as far as can be judged, should become one of the most popular on both sides of the Atlantic. It goes without saying, of course, that the joint work is a great improvement upon the last edition of May. For example, obviously no expense has been spared in the reproduction of wood-cuts, coloured drawings of the fundus, and of external diseases of the eye. Indeed, herein is the feature of the book; we know of no work of the kind in which so excellent and profuse a display of the pictorial art has been made use of. So far as the text is concerned, no detailed criticism is called for, in view of the popularity achieved by previous editions of "May." Suffice it, however, to say that we can confidently recommend the work as a trustworthy guide to diseases of the eye, being, as it is, up-to-date, sound, and practical. Practitioners, therefore, and students alike will find it precisely the kind of work which will meet all their requirements in this regard.

STUDIES IN BLOOD PRESSURE. (*b*)

THE information furnished by the investigation of blood pressure, or hæmomanometry, in diagnosis and prognosis, is gradually becoming more generally utilised As it is still in great measure *terra incognita* to many, Dr. Oliver's practical directions how to take the readings and his indications as to their clinical import will fulfil a want which, if not long felt, is none the less a want. The information is nominally conveyed in two lectures delivered in 1905 at the University of London, the only advantage of this literary form being that the author addresses his readers as "Gentlemen," and is enabled to make a much freer use of the first person singular than would otherwise be becoming. It is but quite recently that a portable instrument has been devised to measure the blood pressure, the importance whereof, empirically estimated by the touch, has long been recognised by physicians. At present quite a number of models are available, and the author pictures a modification of his own. This comports a supplementary pressure-bag for the wrist, the object of which is to provide a more trustworthy index of cessation of pulsation than the finger affords. Lecture I. deals with the technique of the investigation, Lecture II. being devoted to the clinical significance of variations in blood pressure. One of the first points is the unsuspected fallaciousness of digital estimates of arterial tension. The thermometer has its surprises, but they are trivial in comparison, hence the value of a method which enables us to obtain approximately trustworthy data even in inexperienced hands. As with other clinical data, however, the value of the observation lies in its application. It is more particularly in the domain of cardio-vascular disease that observations of blood pressure are of the greatest assistance, but to render the information of practical value the reader must study what the author has to say on this interesting subject.

RATIONAL VOICE PRODUCTION. (*a*)

VOICE production, like the art of the healer of the sick, would seem to engender quackery and charlatanism, and amidst the babel of contending "professors," the serious student and would-be pupil hesitates and is only too often lost in the toils of a "system" which ruins the little voice possessed, and deprives him of the means and opportunities for securing a sure path in what is the most glorious of pursuits. To all desiring guidance and warning, stimulus and scientific exposition whereby the fads and fancies of the extravagant, and the follies and worse of the ignorant may be detected, we commend this most artistic and yet highly reasonable handbook. Mdme. Carolo has done wisely to unite her very fascinating studies of the science and art of voice production to the necessarily somewhat prosaic although eminently practical descriptions of a medical observer. In this work Dr. Daniel deals with the Anatomy and Physiology of Singing, and explains its mechanism. The impediments to an effective use of the voice are described and the advantages and dangers, when improperly employed, of singing are explained in a manner simple and accurate. The most important sections of the work are written by Madame Carolo, with a grace and true artistic appreciation of diction, which, quite apart from the value of the opinions expressed, makes the work one of peculiar attractiveness and exceptional charm. The section dealing with the all-important question of production and control of motive power is a thoroughly scientific exposition on the science and art of "breathing," an all-essential matter on which but few have reliable knowledge. In the limited space at our disposal it is difficult to give any adequate idea of the rational presentation of the artistic suggestions and scientific foundations which are manifest throughout this work; suffice it to say that everyone interested in the development of the voice or desiring to enter into a full appreciation of "the divine gift," should study this remarkable volume. The book is also marked by originality in its illustrations, and in general get-up leaves nothing to be desired.

(*a*) "A Manual of Diseases of the Eye." By Charles H. May, M.D., New York, and Claud Worth, F.R.C.S.Eng. With 20 coloured plates and 315 other illustrations. London: Bailliere, Tindall and Cox. 1906. Price 10s. 6d.

(*b*) "Studies in Blood Pressure." By George Oliver, M.D., F.R.C.P. London: H. K. Lewis. 1906. Price 2s. 6d. net.

(*a*) "The Common Sense of Voice Development." By Irene San Carolo, R.A.M., A.R.C.M., and Patrick Daniel, D.P.H., L.M.S., L.R.C.P., M.R.C.S. Large crown 8vo. Pp. xii., 196. With 12 illustrations. London: Bailliere, Tindall and Cox, Price 5s. net.

MEDICAL NEWS IN BRIEF.

Election of Direct Representatives upon the General Medical Council.

By the time this list is in the hands of the profession, its members will have received the voting papers. It is not for us to urge the claims of any particular candidate, but our columns have been open to the addresses of all. We would, however, urge the importance of every vote being utilised at the present important juncture. The last day for the return of voting papers is December 7th; the declaration of the poll will be made on December 12th. The final list of the English candidates, arranged alphabetically, is:—G. H. Broadbent, M.R.C.S.Eng., L.R.C.S. and L.M.Irel.; G. Brown. M.R.C.S.Eng., L.S.A.; H. Langley Browne, M.D. Birm., F.R.C.S.Edin.; G. Jackson, F.R.C.S.Eng., L.R.C.P.Lond.; H. A. Latimer, M.D.Dun., M.R.C.S. Eng.; L. S. McManus, M.D., M.Ch.R.U.I.; J. Rutherford Morison, M.B.Edin., F.R.C.S.Eng.; C. J. Renshaw, M.D.St.And., M.R.C.S.Eng.; J. M. Rhodes, M.D.Brux., L.R.C.P., L.R.C.S.Edin.; F. J. Smith, M.B.Oxon., F.R.C.P.Lond., F.R.C.S.Eng.; and Joseph Smith, M.R.C.S.Eng., L.S.A. The Scotch candidates are Dr W. Bruce, M.D.Aberd., L.R.C.S. Edin., and Dr. N. Walker, M.D., F.R.C.P.Edin.

Dangerous Industries.

LAST week, in the Commons, Mr. Parker (Halifax), on behalf of Mr. Jowett (Bradford, W.), asked the Home Secretary whether he was aware that during the first nine months of the present year 483 cases of poisoning had occurred among workers in various industries, and whether he could promise early legislation with a view to dealing more effectively with the industries in which the cases occurred. Mr. Gladstone (Leeds, W.): Yes, I am aware of these statistics of poisoning cases for the current year which are compiled by my department. The Home Office has very full powers under the Factory Act of dealing with dangerous trades—in particular by the issue of regulations under Part IV. of the Act. That its action has been attended by a considerable measure of success is, I think, shown by the fact that the number of cases of poisoning has fallen from 1,331 in 1899 to 663 in 1905—a reduction of 50 per cent. in six years. Earlier in the session I laid on the table of the House a memorandum showing the action taken by the Home Office with regard to dangerous trades, to which I would refer the hon. member. Further codes of regulations are in preparation, among which I may mention a code for the horse-hair industries in connection with anthrax, and the revision of the existing codes for paints and colours and the enamelling of metals, which have been found to be inadequate. I may also mention that I am inquiring into the use of poisonous woods in certain manufactures. I do not think I can usefully propose further legislation on the subject at the present time, but, as the hon. member is aware, the Government are taking an important step, and one which I anticipate will have beneficial results, in bringing industrial poisoning within the scope of the Workmen's Compensation Bill.

The Leeds Nursing Scandal.—A Sensational Development.—An Arrest Followed by Suicide.

LAST week the case concerning a Leeds private "maternity home" has taken a sensational turn. On Monday the police arrested a man, aged 42, named Arthur Manson Craythorne, and charged him with using a surgical instrument for an illegal purpose. During the same night Craythorne put an end to his life, using, it is said, morphia for the purpose. The dead man, it appears, had been educated for the medical profession, but he never became a legally qualified practitioner. Up to five years ago he was dispenser and assistant to a well-known Leeds surgeon. Since then he has occupied a consulting-room in Pontefract Street, and set up a sort of irregular medical practice. His attractive personality drew around him many friends, and he was generally "hail fellow well met" amongst his acquaintances. But he never got through his examinations, and remained unqualified. He was married, but had no children.

Munificent Gifts to Medical Charities.

MR. H. L. BISCHOFFSCHEIM, in order to express his happiness on reaching his golden wedding, has given £100,000 to medical institutions of the metropolis:—Cancer Research Association, £40,000; the King's Hospital Fund, £10,000; the King's Sanatorium, £10,000; Charing Cross Hospital, £2,500; Great Ormond Street Children's Hospital, £2,500; London Hospital, £2,500; Middlesex Hospital, £2,500; Queen Charlotte Lying-in Hospital, £2,500; Metropolitan Provident Medical Association, £2,500; St. George's Hospital, £1,000; Surgical Aid Society, £1,000; Convalescent Homes Association, £1,000; Daneswood Sanatorium, £10,000; Tudor House Sanatorium, £6,000, etc.

Discovery in Yellow Fever.

A REUTER telegram has been received from the expedition of the Liverpool School of Tropical Medicine which has been in Brazil since the commencement of 1905 with the object of making research into yellow fever. It states that the expedition has just been successful in proving that chimpanzees can be infected with yellow fever by means of the Stegomyia mosquito. This discovery will be of the highest importance to those carrying out investigations into the disease Both the medical experts of the expedition contracted yellow fever in the earlier stages of their investigations.

Preservatives in Food.

A CONFERENCE, under the auspices of the Incorporated Institute of Hygiene, on "Preservatives in Food: their Use and Abuse," will take place tomorrow (Thursday). Professor Tunnicliffe, M.D., who was a prominent member of the Commission appointed by the Local Government Board to inquire into this subject in 1899, will preside.

The Anti-Opium Regulations.—Opinions in Shanghai.

THE native Press, says the *Times*, is curiously reticent on the subject of the new regulations for giving effect to the edict for the abolition of opium smoking The explanation given by the editors is that they prefer to await the issue of the further edict and proclamations necessary. The local foreign Press recognises the importance of these regulations, if only because they afford undeniable proof of the sincerity of the progressive party's desire for radical reform and their influence with the Central Government. Hearty sympathy is expressed with the action of the Throne in supporting measures which, if effectively enforced, must confer the greatest benefit on the nation, while the practical, businesslike wording of the regulations meets with general approval. At the same time the very vastness of the scheme compels a suspension of judgment, and induces doubt of the possibility by an act of legislation of compelling 150 millions of people to discontinue the opium habit. It is recognised that the practicability of this stupendous reform depends chiefly on the loyal co-operation and self-denial of the provincial officials, many of whom will be compelled to retire into private life, while others will be deprived of an important source of revenue.

Public opinion, native and foreign, strongly supports the anti-opium movement. Nevertheless the

vested interests of the yamens and the opium dealers will naturally be opposed to the reform. Finally, it is recognised that, if the regulations are hereafter compromised or abandoned owing to the Government's inability to enforce them, a severe check will have been inflicted on the progressive party in Peking—a consideration which must stimulate reactionary activity on this question. The urgency of the regulations and the early abolition of all opium divans creates a situation of remarkable interest.

The Hastings Libel Case.

ANDREW DUNN TURNER, surgeon, who pleaded guilty on the previous evening to publishing to Edward Thomas Burchatt Austin a letter containing divers false, scandalous, malicious and defamatory matters concerning the character of Kate Austin, his daughter, at Hastings, came up for sentence. Addressing his lordship on prisoner's behalf, Mr. Horton Smith said this man's life had been one of considerable pain, and the things which he said in the letter he had done were merely the imagination of a disordered mind. Years ago he received a very severe injury to his thigh, and had undergone no fewer than nine operations. He had been driven by the pain to take a large quantity of morphia, the effect of which was to cause not only physical, but moral and mental degeneration. Testimonials he had showed that from 1877 down to a recent date prisoner had stood high in his profession, and was of high moral character. The Salvation Army were prepared to receive the prisoner into a home.—Mr. Frank Septimus Barnett, M.R.C.S., speaking from a knowledge of prisoner for sixteen or seventeen years, said few men had suffered more actual pain over such a long period as prisoner.—His lordship said it was urged that prisoner had given way to taking morphia, but, as a doctor, he must have known the effect, and he was really in the same position as a person who, knowing that drink would be prejudicial to him, still indulged in it. The best thing he could do for prisoner was to keep him where he had been for the past four months—in prison, where every care would be taken of him. He would be sentenced to six months' imprisonment.

Society of Apothecaries of London.

AT the annual dinner of this Society, held a few days since, in the Hall of the Institution, the Master (Mr. E. Parker Young) presided, and among those present were Professor Clifford Allbutt, who, in submitting "The Society of Apothecaries of London," observed that in course of time the Royal Colleges of Physicians, and Surgeons, and the Society must unite into one great academy of medicine. The profession was suffering badly from the present divisions. They knew there were honourable men in its highest ranks who practised both medicine and surgery, and the distinction was a hollow one. The Master gave "The Royal Colleges of Physicians and Surgeons," and alluded to the society's work in advancing medical science and in keeping up the standard of their examinations. He remembered that it had about 10,000 Licentiates. Examining the statistics of the candidates appearing for examination for naval and military commissions last year, he found that the Licentiates of the Society stood first. They were trying, by a private Act, to alter their title, and the General Medical Council had very kindly offered no opposition. He thought that the public did not quite understand that they gave an examination in midwifery, medicine, and surgery. Mr. Henry Morris, President of the Royal College of Surgeons, replying for both institutions, said that the two Royal colleges were intimately associated with the origin and development of the Society. The differentiation of the profession into physicians, surgeons, and apothecaries, or general practitioners, was also associated with the origin and growth of the pharmacopœia and the establishment as a complete order of the pharmaceutical chemists and druggists. This differentiation of the profession afforded an excellent illustration of the way in which the dissensions, the jealousies, the ambitions, and the self-interest of different sections of society might be for the general good and the public profit, provided that there were behind high principles and worthy motives.

United Kingdom Hospitals Conference.

A conference of representatives of hospitals and others interested in the problem understood by the term "Hospital Abuse," will be held in the theatre of University College, London, on Thursday, December 6th, to co-operate with the members of the Hospitals Committee of the British Medical Association in revising and extending the proposals of a previous conference, and to express their opinion on the matters submitted. Over 150 hospitals have appointed representatives to take part in the forthcoming proceedings.

Fined for Non-Notification.

AT Dudley Police Court last week Dr. Maclure, of Brierley Hill, was fined 20s. and costs for failing to notify a case of puerperal fever to the medical officer of health. Dr. Maclure's defence was that he was not called in until the woman was in extremis, and when she died he reported it to the police.

Conviction under the Medical Act.

THE Stipendiary at Chatham has fined George Charles Smith £25 and costs for using the title of surgeon-dentist after his name had been struck off the Register of the British Dental Association. The magistrate said the defendant had been previously convicted at Lewisham, and the maximum penalty had been imposed to bring him to his senses, as he was deliberately flying in the face of the law. Defendant stated that the Association struck him off because he canvassed for business, and because he supplied artificial teeth on the deferred payment system.

Fire in a Bacteriological Laboratory.

On Sunday night an explosion occurred in the laboratory of the Mercy Hospital, Pittsburg. Many hundreds of tubes containing cultures of various pathogenic micro-organisms were smashed, and their contents were scattered far and wide. The inhabitants of the town were thrown into much alarm on learning of the accident, and extraordinary precautions are being taken to prevent the spread of any diseases that might possibly arise from the accident.

Society of Apothecaries of London.

THE following candidates, having passed the necessary examinations, have received the L.S.A. Diploma of the Society, entitling them to practise medicine, surgery, and midwifery:—L. C. W. Brigstocke, F. G. Edholm, C. J. M. Lawrence, W. S. Mitchell, L. Nicholls, and J. W. Peatt.

Royal College of Surgeons, Ireland—Dental Examination.

The following candidates, having passed the necessary examination, have been admitted Fellows of the College:—A. Leventon, L.R.C.S.I., etc., Captain I.M.S.; W. L. Martin, L.R.C.S.I., etc., Surgeon R.N., and A. W. Tuke, M.R.C.S.Eng., Captain I.M.S. The following candidate passed the Primary Part of the examination: Mr. H. S. Meade.

THE following candidates having passed the necessary examination, have been admitted Licentiates in Dental Surgery of the College:—Mr. W. T. Anderson (Galway), Mr. P. M. Black (Dublin), Mr. R. F. Cooper (Wexford), Mr. J. E. Hogan (Dublin), Mr. P. D. McCreery (Kilkenny), Mr. A. K. Macdonald (Dublin), Mr. T. J. Ollivere (Cork).

Trinity College, Dublin.

THE following candidates passed the Final in Medicine, Michaelmas, 1906:—Thomas O. Graham (passed on high marks), Cecil T. Conynyham, John Gray, Percy B. Egan and Dudley F. Torrens (equal), Arthur E. Knapp, James E. McFarlane, Thomas B. W. MacQuaide.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT PATHOLOGICAL LITERATURE.

The Cardio-Vascular Lesions of Chorea.—Thayer (*Journal of the American Medical Association*, October 27, 1906), analyses the records of 808 cases of chorea, with special reference to the cardiac and vascular lesions discovered. He notes the frequency with which a history of rheumatism was obtained, in spite of the fact that rheumatism in children commonly runs a mild and atypical course. In 175 cases organic lesions of the heart were deemed probable; 111 of these were cases of mitral insufficiency, 7 of mitral stenosis, 39 of double mitral disease, 10 of mitral and aortic insufficiency, 1 of mitral stenosis and aortic insufficiency, 1 of double mitral disease and aortic insufficiency, and 6 of acute endocarditis, probably mitral in situation. Thayer finds, further, that cardiac involvement was more common in cases where there was a history of acute polyarthritis, and also in cases where there were frequent recurrences. R.

The Blood Pressure in General Paralysis.—Walton (*Journal of the American Medical Association*, October 27, 1906) sets himself to disprove the common notion that general paralysis is accompanied by a low blood pressure. His observations were made on 108 male patients, 64 of whom suffered from definite cardiac, renal, or arterial disease. He concludes:—(1) The average blood pressure in general paralysis is high; (2) this is due to the prevalence of atheroma, with its cardiac and renal accompaniments; (3) the average blood pressure in cases of general paralysis without arterial, cardiac, or renal disorder is probably lower than in health; (4) the test is not likely to be of any diagnostic value. R.

The Blood in Yellow Fever.—It has long been taught that in yellow fever the histological elements of the blood underwent complete dissolution, and that the blood as a whole became more fluid than normal, losing its coagulability. Modern investigation by Sternberg, Finlay, and others has shown the falsity of the first of these propositions. Marks (*American Journal of the Medical Sciences*, November, 1906) disproves the second. In the case of eight typical cases of yellow fever, he has tested the coagulability of the blood, with Wright's coagulameter. The minimum time occupied in coagulation was two minutes and forty-five seconds, the maximum four minutes and twenty seconds, the average three minutes and fifty-two seconds. From these results there can be no doubt that the coagulability of the blood is normal. R.

Hodgkins' Disease and Lympho-Sarcoma.—All who have studied the condition of the glands in Hodgkins' disease and in lympho-sarcoma have been struck by a remarkable similarity of structure, and during the past few years the view has been put forward that the diseases are of the same nature, differing, if at all, only in degrees of chronicity. Gibbons (*American Journal of the Medical Sciences*, November, 1906), from a study of nine cases of one or other disease, strongly supports this view. Six of the cases correspond in every way to the clinical and pathological type known as Hodgkins' disease, while the other three were of an undoubted malignant character, the disease affecting not only the lymphoid tissues, but infiltrating adjacent structures. The clinical picture in all the cases, however, was very similar, and the histological structure showed no point of distinction. The lymph-glands over the whole body were involved, and in those which came to the *post-mortem* table, five in number, metastases were found in the liver in four, in the spleen in four, in the kidney in two, in the lungs, the pericardium, and the pancreas, in one each; while in three of the cases the picture of malignant infiltration was complete, in the others, although the surrounding structures were intact, the capsule of the gland was infiltrated. Apart from the undoubted malignancy of some of his cases, Gibbons argues strongly that the histological structure is more suggestive of neoplasm than of infective granuloma. The irregularity of arrangement, the character of the fibrous stroma, the large number of mitotic figures, and the nature of the giant cells occasionally encountered, are points in favour, he thinks, of the disease being a form of sarcoma. R.

Further Studies in Syphilis.—Metchnikoff and Roux publish (*Annales de l'Institut Pasteur*, October 25, 1906) a further memoir dealing with their experimental researches on syphilis. (1) They relate certain experiments which go to show the possibility of attenuating the syphilitic virus by passage through animals. It was found that when a number of baboons were inoculated in series, the time required for symptoms to appear gradually grew shorter. Thus, in one series, from 19 days at the start, the periods diminished, till at the ninth passage only eight days were required. From this shortening of the period of incubation, one may assume a gradual heightening of the virulence toward the particular species employed. At the same time, however, there was a decreased virulence toward other species. Thus, a chimpanzee—the animal next to man most susceptible to syphilis—was inoculated with virus from a baboon at the eleventh passage without any sign of syphilis supervening; a baboon inoculated with the same virus showed typical lesions in nineteen days. Other chimpanzees, inoculated at the sixth and seventeenth passages, also remained free of the disease. In the human subject also, Metchnikoff and Roux believe to have observed syphilis of an attenuated virus. One of their laboratory attendants accidentally inoculated himself on the lip while caring for the animals used as subjects of experiment. The resulting ulcer did not clinically suggest syphilis; there was no glandular enlargement, and there were no later symptoms. Several apes, including three chimpanzees, were inoculated from the sore. The chimpanzees remained well, but several baboons of various species developed typical syphilitic lesions. One may conclude that the syphilis from which the attendant suffered was of attenuated virus not only to man but to the chimpanzee. Determined to put the point to further test, the investigators inoculated with syphilis at the fifth passage an old woman of 79, who submitted herself for experiment. At the same time, and with the same material, they inoculated a chimpanzee. Both subjects developed slight papules at the seat of inoculation, more marked in the ape, but neither showed any further sign of syphilis. From these various observations the authors conclude that there is a possibility of obtaining a vaccine for syphilis. In the absence of dead organisms, this can only be got by attenuating the living virus by passage. They suggest the advisability of submitting prostitutes at the beginning of their career to such vaccination. No harm can be done, they claim, since persons of this class are almost certain, if unprotected, to suffer from the disease eventually. In countries, too, like Russia, where extra-genital syphilis is rife, the question of vaccination as a general prophylactic measure might be discussed. (2) The authors discuss further, and defend against criticism, their views as to the possibility of preventing syphilis by the aid of calomel ointment. They hold that the failure of other observers to parallel their own success was due either to the use of too weak an ointment, or to allowing too long a period to elapse after infection before inunction was practised. They believe that the ointment should

contain from 25 to 33 per cent. of calomel, and that it should be applied within a few hours of infection. R.

Primary Cancer of the Ovary.—Miss McIlroy (*Journal of Obstetrics and Gynæcology of the British Empire*) publishes an important study of this condition, viewed from both the clinical and pathological standpoints. Among the conclusions are: (1) Most frequently both ovaries are affected, the one showing a more advanced condition than the other. (2) In the early stage the capsule is firm, being composed of fibrous tissue; later it becomes friable, and the tumour tissue forms surface proliferations. (3) Evidence of previous benign change in the ovary is usually to be found. (4) The epithelial cells are derived from the cells lining the follicles and from the cells derived from the germ epithelium. Karyokinesis is present. R.

Behaviour in the Body of Certain Organic and Inorganic Compounds of Phosphorus.—Dr. Tunnicliffe contributes a paper on this subject to the *International Archives of Therapy* for this year. After briefly reviewing the previous work that has been done on the subject, he sets himself three questions, which he has attempted to answer by observing the metabolic changes in two children to whom organic and inorganic phosphorus compounds were intermittently administered. The questions were—(1) Is it possible in the healthy human child to increase the amount of phosphorus retained in the body by increasing the phosphorus of the diet; (2) how do organic and inorganic phosphorus compounds compare in value as sources of phosphorus to the body; (3) what is the effect of phosphorus compounds on proteid assimilation. The conclusions that he has arrived at are important, and are stated as follows:—(1) In the healthy child the addition of an organic phosphorus compound to the diet is followed by an increase in the amount of phosphorus assimilated by and retained in the body; (2) the exhibition of an organic phosphorus compound increases the amount of the nitrogen of the food assimilated; (3) inorganic phosphorus compounds exert no favourable influence on nitrogenous assimilation, nor do they lead to an increase of prosphorus retention; (4) the phosphorus contained in the sodium glycero-phosphate of casein is practically entirely assimilated by the body. M.

Sahli's Desmoid Reaction.—A paper on this subject is contributed by Dr. Boggs to the *Johns Hopkins Bulletin* for September, 1906. The test, as is well known, is employed for the purpose of discovering the digestive power of the gastric juice, and consists of the following:—A pill is made out of a grain of methylene blue and a little liquorice powder, and is wrapped up in a rubber sack, the neck of which is tied by three turns of oo catgut; this is administered to the patient, and the time when the urine becomes blue is noted. As catgut can only be digested by the acid gastric juice, and is unaffected by trypsin and other intestinal enzymes, the time of appearance of the reaction indicates the activity of gastric digestion. The time of appearance may vary from five to twenty hours. The writer has examined 34 patients suffering from gastric symptoms, and has compared his results with results obtained by chemical analysis of the gastric juice in the same cases. His conclusion is that the method is valuable and reliable. In seven cases of stomach cancer the test was entirely negative in six, and the result doubtful in the seventh; and in seven cases of pernicious anæmia it was also negative. In all of these fourteen cases the chemical analysis showed the absence of hydrochloric acid; also in every case that HCl was found by analysis the desmoid test was also positive. He regards Sahli's test, however, as more delicate than the analytic test, as the pill, being heavy, remains in the stomach for the maximum time, and so tests fully the gastric digestive powers. M.

Aneurism of the Splenic Artery.—A case of this rare condition is reported by Dr. Reynolds (*South African Medical Record*, September, 1906). The patient was a female, æt. 28, who complained of pain in the back to the left of the middle line, and of flatulence. There was no history of syphilis, and no physical signs could be detected. Death occurred suddenly while the patient was in bed. At the autopsy the spleen was found much enlarged, and an aneurism was present on the splenic artery. This was about two and a half inches in diameter, was half filled with decolourised clot, and presented a ragged opening through which a finger could be passed. Rupture had taken place into the peritoneal cavity, which was full of blood. The author points out that only about twenty case in all of splenic aneurism have been recorded, and that it has almost invariably been unsuspected during life. M.

The Pathology of Chorea.—Drs. Poynton and Gordon Holmes record the result of their recent investigations into the etiology and pathology of chorea (*Lancet*, October 13, 1906). Their report is founded on the examination of the brains of three fatal cases of the disease. In each of the cases they found great hyperæmia of the brain cortex and of the meninges, and in many cases thrombosed vessels. Patches of necrosis were also found, and a very constant feature was perivascular small round celled infiltration and serous exudation. Many nerve cells presented chromatolysis. In all of the cases also diplococci were found in the vessels of the meninges and in the walls of some of the blood-vessels within the substance of the brain. Similar organisms were obtained in one case from the heart valves in pure culture, and were found to produce multiple arthritis and pericarditis when injected into animals. The authors, as a result of their findings, conclude that chorea is not a complication but a result of the rheumatic process, and that the symptoms are produced by the action of a toxin on the nerve cells—the toxin itself being the product of the diplococcus rheumaticus, which organism they believe to be identical with that they have observed in the brain in choreic cases. M.

Blastomycosis of the Skin.—Primrose describes a case of this rare pathological affection (*Edin. Medical Journal*, September, 1906). The disease occurred in a man, æt. 28, and took the form of multiple skin tumours, fourteen distinct lesions in all being present. One patch on the upper lip resembled closely an epithelioma. It was about an inch in transverse and vertical diameters, and was raised considerably above the surface. It presented a warty appearance of a dirty yellowish colour, with here and there some hæmorrhagic spots; the base was not indurated, and the growth stopped quite abruptly, the surrounding tissues being apparently quite healthy. Similar lesions were present on the cheeks, at inner canthus of the eye, on the trunk, and on the extremities. Scrapings made from the patches and teased out in liquor potassæ revealed blastomycetes in the form of round, highly refractile, double-contoured bodies; while sections made of an excised portion showed epithelial hyperplasia, hyperæmia, leucocytic infiltration, and small abscesses. In the neighbourhood of the abscesses there were patches of granulation tissue containing giant cells and epithelioid cells. Under treatment the tumours rapidly improved. M.

Leprosy in Buenos Ayres.

AT the fifth sitting of the conference on leprosy, today, Dr. Sommer and Dr. Aberastain stated that leprosy was obviously increasing in Buenos Ayres, and that rigorous measures must be taken.

IT is announced that the fifth periodical Congress of Gynæcology, Obstetrics, and Pædiatrics, will be held at Algiers, April 1st to 8th, 1907, under the general presidency of Professor Queirel, of Marseilles, who will also preside over the Section of Obstetrics. Dr. Boursier, of Bordeaux, will be President of the Gynæcological Section, and Dr. Guinon, of Paris, of that of Pædiatrics. The General Secretary is Professor Jules Rouvier, 52, Rue Daguerre, Algiers, to whom all communications should be addressed.

NOTICES TO CORRESPONDENTS, &c.

☞ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to 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 proofs.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions, the same rule applies as to office; these should be addressed to the Publisher.

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.

SUBSCRIPTIONS.

SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance.

TAN.—It is yellow phosphorus, also known as white phosphorus, which is the chief cause of industrial phosphorus poisoning. But the trichloride is used in small quantities in some manufactories. The sesqui-sulphide can be, and now is, largely used in match-making.

MR. W. W. RUTHERFORD, M.P., AND THE HERBALISTS.

THE *Liverpool Daily Courier* is responsible for the following extraordinary statements by an English member of Parliament regarding the suggested Government recognition of the herbalists as a professional body. It is difficult to realise how any man occupying so responsible a position could have committed himself to the attitude revealed in his answer to a Mr. Cowie, giving an account of his successful treatment of cancer with violet leaves! The *Courier* reports Mr. Rutherford as writing:—"What I think will eventually happen is that a general Bill will be brought in enabling all such professions and businesses to be registered as a sort of Incorporated Society; and I confess, for one, that, having regard to the considerable number of herbalists who are reasonably qualified to carry on their business, and having regard also to a number of other people who set up as such, and who are not so qualified, it would be exceedingly desirable that the properly qualified body should be recognised as one of the societies which would come within purview of such a Bill."

RETRACTOR.—The poison you speak of—tyrotoxicon—is a rare one in cheese. Probably poisonous cheese is due to micro-organisms. Some bacilli resembling in some respects B. coli communis have been found by different observers.

OPSONIN.—The suggestion is a good one and you might submit it to your colleagues in the neighbourhood—say by resolution at your medical society. If opinion is decided on the point, we should be glad to hear.

TABLOIDS v. TABLONES.

IN our issue for the 14th inst. we referred to a case just decided in the High Court, in which Messrs. Burroughs, Wellcome and Co. sued the Capsuloid Company, Limited, for an infringement of their brand "Tabloids" by the newly-coined word "Tablones." By a slip of the pen we referred to the infringement as "Capsuloids," whereas that complained of by Messrs. Burroughs, Wellcome and Co. was "Tablones," by the Capsuloid Company. Our attention having been called to the slip, we are glad to make the necessary correction.

DR. McV.—We thank you for the cutting, which is most interesting. As, however, the circumstances alluded to in the article have not fully come under our notice, we cannot comment on them clearly. It is refreshing to have appreciative reference in the lay press after so much that one sees.

GLOXIENSIS AND CORASSA.

A CORRESPONDENT asks what was the sequel of this case, to which we referred three weeks ago. The case came on at the Sussex Assizes on Monday last, and ended with a sentence of three months' hard labour for obtaining money by fraud. The quack, it may be remembered, advertised from Brighton some marvellous powders under the above descriptions, which would cure everything to which "flesh is heir." He was doing a big trade as Dr. Hawkins, M.D. U.S.A., when the police inconsiderately intervened, took possession of his person and the precious powders, and for their pains have now the trouble of looking after him for the next three months.

DR. H. J.—The question was answered in this column last week.

AN INTERESTED CONTRIBUTOR.—The question is under consideration.

F. H. T.—The combination of the two names is curious, and we trust genuine. One cannot forget that any combination is possible. There are even two Winston Churchills. It is possible to take steps only if the name has been adopted obviously for fraudulent purposes.

► DR. S. T.—Stricture of the urethra in women is, as you say, rare, but a certain amount of narrowing is not so very uncommon. As in the male, gonorrhœa is the chief cause.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, NOVEMBER 28th.

HUNTERIAN SOCIETY (London Institution, Finsbury Circus, E.C.)—8.30 p.m.: Pathological Meeting.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. P. J. Freyer: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. J. Fawcett: Some Pathological Specimens with Interesting Clinical Histories.

THURSDAY, NOVEMBER 29th.

NEUROLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street, Cavendish Square, W.).—9 p.m.: Hughlings Jackson Lecture:—Sir Victor Horsley: The Illustration by Recent Research of Dr. Hughlings Jackson's Views on the Functions of the Cerebellum.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.)—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. A. Carless: Some Injuries about the Elbow-joint.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m.: Chesterfield Lecture:—Dr. M. Dockrell: Coccus Diseases: I., Impetigo Contagiosa; II., Furuncle; III., Carbuncle; IV., Coccogenic Sycosis.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Mount Vernon Hospital, Hampstead).—5 p.m.: Demonstration: Dr. J. E. Squire: Cases of Chest Disease.

FRIDAY, NOVEMBER 30th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.:—Mr. E. Clarke. Clinique. (Eye.)

Vacancies.

Royal Hospital for Incurables, Donnybrook, Dublin.—Resident Medical Officer. Salary £120 per annum, with board, &c. Immediate application to J. J. Thompson, Registrar. (See advt.)

Bristol General Hospital.—Senior House Surgeon. Salary £150 per annum, with board, residence, &c., in the house. Applications to the Secretary.

Royal South Hants and Southampton Hospital.—House Physician. Salary £100 per annum, with rooms, board, and washing. Applications to T. A. Fisher Hall, Secretary.

Stretton House Private Asylum.—Indoor Assistant Medical Officer. Salary £150 per annum. Applications to Dr. Barnett, Stretton House, Church Stretton. (See advt.)

Bridge of Weir Consumption Sanatoria.—Assistant Resident Medical Officer. Salary £100 per annum, all found. Applications to R. Lockhart Bryden, Hon. Secy., 102 Bath Street, Glasgow.

Leeds University Faculty of Medicine.—Demonstrator of Bacteriology. Salary £200 per annum. Applications to the Registrar of the University.

County Asylum, Prestwich, Manchester.—Junior Assistant Medical Officer. Salary 150 per annum, with board, furnished apartments and washing. Applications to the Medical Superintendent.

Glamorgan County Asylum, Bridgend.—Junior Assistant Medical Officer. Salary £150, with board, apartments, attendance, and washing. Applications to the Medical Superintendent.

Manchester Royal Infirmary.—Resident Medical Officer. Salary £150 per annum, with board and residence. Applications to the Chairman of the House Committee.

Blackburn County Borough.—Education Committee.—Assistant to the Medical Officer of Health. Salary £150 per annum. Applications to Alexander Gow, Director, Education Offices, Library Street, Blackburn.

Appointments.

FLEMING, R. J., M.B., B.S.Durh., District Medical Officer by the Devonport Board of Guardians.

FORSYTH, CHARLES E. P., M.B.Aberd., Assistant Pathologist in the London School of Clinical Medicine, Seamen's Hospital ("Dreadnought"), Greenwich, S.E.

FULLAM, W. F., L.R.C.S.Irel., L.A.H.Dub., Certifying Surgeon under the Factory and Workshop Act for the Balbriggan District of the county of Dublin.

MORRICE, G. G., M.D.Cantab., M.R.C.P.Lond., Consulting Physician to the Royal Dispensary, Portland.

PATTERSON, NORMAN, M.B., B.Ch.Edin., F.R.C.S.Eng., Senior Clinical Assistant to the Golden Square Throat Hospital.

WADIE, M.D., M.R.C.S., L.R.C.P.Lond., House Surgeon to St. Peter's Hospital for Stone, London, W.C.

WEAR, ALGERNON, M.D., B.S.Durh., Honorary Medical Officer in Charge of Medical Cases at the Southern Branch of the Leeds Public Infirmary.

WHITFIELD, ARTHUR, M.D.Lond., F.R.C.P.Lond., M.R.C.S., Professor of Dermatology at King's College, London.

Birth.

BULLOCK.—On Nov. 22nd, at 26, Cyril Mansions, Battersea Park, Marian T. Bullock, M.B. Lond., wife of W. Carey Bullock, of a daughter.

Marriage.

TUNSTALL—SILBERSCHMIDT.—On Nov. 10th, at Holy Trinity, Sydenham Park, Alfred Croudson Tunstall, M.D., F.R.C.S. Edin., of S. Hackney, to Florence Adeline, eldest daughter of Moritz S. N. and Adeline S. E. N. Silberschmidt, of Rothay House, Sydenham.

Deaths.

GUTHRIE.—On Nov. 23rd, at 35, Briardale Gardens, London. Jessie Rose Black, widow of John Guthrie, M.D., of Brechin, N.B., in her 77th year.

SPAIGHT.—On Nov. 22nd, at Swiss Cottage, Dundrum, Co. Dublin, Alice Maude, widow of the late Robert Spaight, J.P., Affock, Tulla, Co. Clare, and daughter of the late James Molony, F.R.C.S.I., Clonmore, Tulla.

SYMES THOMPSON.—On Nov. 24th, at 33, Cavendish Square, London, Edmund Symes Thompson, M.D., F.R.C.P., aged 69.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIII. WEDNESDAY, DECEMBER 5, 1906. No. 23

NOTES AND COMMENTS.

C.B. and the R.C.S.

THE persistent *hauteur* with which the Fellows of the Royal College of Surgeons regard the claims of the members to a voice in the government of the College is sufficient evidence of the cynical indifference of this corporation to the needs of the profession. The Fellows are, roughly speaking, consultants, and the members general practitioners. The Fellows elect the Council, control the College, appoint themselves examiners, and send a representative to the General Medical Council to see their "rights" are not infringed; the members, after paying very substantial fees for examination, are allowed to go into the world and fend for themselves. The College is not for them, and takes no further interest in them unless they misconduct themselves. The position is intolerable to all who realise the struggle of the general practitioner against outside odds, and that he should be wounded in the house of his friend is a bitter comment on the generosity of the more highly placed members of the profession. One cannot be over sanguine of Government interference, but we note with pleasure the courageous action of Sir William Collins and Mr. R. J. Price in personally laying the position before the Prime Minister. Sir Henry Campbell-Bannerman received them sympathetically, and said that he would look into the matter. More than this, perhaps, could not be expected, and it is difficult to see how the Government can take action. We hope, however, that there may be machinery which we know not of, and which may be set in motion as the result of the deputation.

Increased Clinical Instruction.

THERE is no doubt that increased clinical instruction in certain subjects is not only desirable, but is a necessity. Amongst such subjects, obstetrics, gynæcology, and diseases of children stand out prominently. It is absurd to think that a newly qualified medical man can successfully practise obstetrics on the amount of clinical teaching which is at present considered sufficient for him, and yet obstetrics is the very subject in which he stands in need of careful training. It is therefore satisfactory to learn that at the meeting of the General Medical Council referred to elsewhere, which rejected Sir Thomas Myles' motion to make students' lectures non-compulsory, it was resolved, on the motion of Mr. Young, "That it be remitted to the Students' Practical Midwifery Committee to consider and report as to the inclusion of clinical and practical work in the qualifying examination in midwifery and gynæcology." If it could be clearly proved the student had not time in the present crowded state of his curriculum to take up also such clinical and practical work, it would be a strong argument in favour of Sir Thomas Myles' proposal. Unfortunately, however, midwifery is the very subject in which it would be impossible to abolish systematic lectures, whose value, here at least, has been fully admitted. If surgical teachers have doubts as to the value of systematic lectures in surgery, would they be willing to see them abolished in order that the student should receive fuller practical instruction in midwifery and gynæcology?

Apothecaries' Act.

IT is one of the queer survivals of ancient practice that the Apothecaries' Society, though empowered to grant licences to practise medicine and surgery, are not able to call their licentiates physicians, surgeons, or doctors. Consequently the uninstructed public cannot distinguish the practitioner of medicine from the dispenser of physic, the term "apothecary" having from time immemorial been associated in their minds with a pharmaceutical chemist. As a matter of fact, the legal decisions with regard to the proper description of an L.S.A. are conflicting, but judges have recognised it as a hardship that a legally qualified practitioner in medicine or surgery cannot adopt the style which describes him to the public as such. We are not surprised, then, that the Apothecaries' Society intend to apply next session for an Act to empower them so to describe their licentiates that people may know them for what they are; the only opposition we can think of would come from those who might be inclined to think that such a step would postpone the "one-portal" system.

The Only Portal.

THE one-portal is bound to come sooner or later, and is sure to be strongly opposed by those corporations, such as the Royal Colleges, which draw the bulk of their income from examining, and regard their charters as conferring on them privileges for which they need make no return to the public or their diplomates. But it is only rational that the register should show what it is intended to show, namely, that all medical men have attained a certain substantial standard of knowledge, and not that they find their place on it by virtue of the approval of a body which trades in examinations. It is an absurd anomaly that a man may pass qualifying examinations and yet not be able to call himself "doctor," the one term whereby the public recognise the medical practitioner from the quack. "Registered Medical Practitioner" is about as useful an asset in practice as "Registered at Stationers' Hall" would be.

LEADING ARTICLES.

THE GENERAL MEDICAL COUNCIL.

THE General Medical Council have held their winter session, and from the President's address at the outset it was clear that the policy of marking time was to be pursued, probably because of the election in progress. As to that election, it may safely be said that it shows signs of being more keenly contested than any that has yet taken place, and we trust that it will be found that no practitioner has failed to register his vote. One of the arguments that is used with great unction by the opponents of increased direct representation is that medical men show so little interest in present elections that it would be folly to give more power into their hands. We do not agree with this conclusion, but we hold strongly that any man who fails to register his vote shows a want of loyalty to professional ideals that is highly blameworthy. If a man is not satisfied with things as they are, he cannot blame anyone but himself if he fails to use his vote; and if a man is satisfied, then the call to vote is even greater, for he has a multitude of professional brethren to whom the conditions of life are terribly hard and unfair. Only direct representatives have shown themselves in deadly earnest about the reform of medical grievances, the excellent people who are deputed to represent corporations and universities regarding such matters as questions of academic interest, quite subordinate in importance to the teaching of biology and the sanctioning of places where instruction in chemistry may be given. The Council needs good, hard-headed direct representatives; it needs men of position and integrity; but, above all, it needs fighters who can infuse into its august proceedings that spirit of enthusiasm which takes no count of difficulties. The direct representatives are the Labour party of medical politics, and, without dwelling on the special merits or demerits of Parliamentary issues, it is agreed on all hands that the Labour men in the House of Commons, though few in number, have made themselves an irresistible force. They have won this position by doggedness, determination, diligence, knowledge of what they want, and downright earnestness. Those are the qualities which we look for in direct representatives in the General Medical Council, and they will more than ever be needed now that Sir Victor Horsley has retired. The atmosphere of the Council is as serene as that of the House of Lords, and courage of no mean order is required to electrify it. We believe that this election is showing, and will show still further, that the general practitioner has bestirred himself, and that he expects from his representatives that unwearied forcing forward of pressing questions, and that discriminating forcing back of insignificant ones, which will lead to substantial reform. Looking through the agenda of this session of the General Medical Council, one would imagine that everything was for the best in the best of all possible worlds. A few trifling questions of the medical courses of study in Japan and Nova Scotia, some points about the teaching of midwifery, and minor alterations in the inspection of examinations formed, with the usual penal cases, the bulk of a bill of fare as jejune and unsatisfying as one could wish. We may, however, congratulate the General Medical Council on having successfully opposed the granting of charters to the British Optical Association and to the National Association of Medical Herbalists of Great Britain, Limited. The fight against the former is likely, we fear, to be a Pyrrhic victory ardently followed up, for the Association are seeking to turn the flank of medical opposition by means of a Bill in Parliament, which has powerful backing. This Bill must be carefully watched and vigorously met in every stage of its career, for it seeks to go back, as the Medicines Act has already gone back, on the principle of the Medical Act of 1886, when the one and indivisible nature of medicine, surgery, and midwifery was recognised by the Legislature. That position, it was hoped at the time, had been established for ever as the foundation of all progressive medical legislation. In spite, however, of the set-back received when the Midwives Bill passed in its final shape, it must never be conceded that it is possible for proper treatment of such persons to be undertaken by other than those trained in the three fundamental branches of medical science and practice. The Herbalists' Charter, as we have said before, hardly savoured of the serious; it was such manifest "cheek" for a body of worm-curers or weed-sellers to claim medical powers of any kind. These victories, important enough in themselves, can hardly be regarded as heroic, and they represent substantially all that the Council has achieved in the support of medical interests in what we may term its external relations. The President had to announce that, "acting on advice that it could not disregard," the Executive Committee had decided not to submit to Parliament the Bills they had prepared to remedy existing abuses. Well, there are always advisers ready to suggest delay, caution, and prudence; the profession want men who are ready to hit, to hit hard, and to take risks. It wants men prepared to tell the Council that it is badly constituted, that it does not represent the feelings of the medical profession, and that it must begin reform by letting Parliament know that it cannot do effective work till it is purged itself. We do not deny that the work of the Council has been uphill and that it has had to make its own position in the officially-recognised world, but its path would have been easier if it had had the whole-hearted support of its nominal constituents. One day the Council will awake to the fact that the profession is one of the most influential bodies in the community; that the practitioner of medicine is the friend and adviser of every household; and that if the machinery were put into working order public support of the medical view could be obtained in every nook and cranny in the land.

NOTES ON CURRENT TOPICS.

A Doctor's Dilemma.

As a leading dramatist Mr. G. Bernard Shaw well deserves the epithets of brilliant, witty, and original. His latest effort deals with the medical profession much on the lines of Molière. In a good-natured way he brings together on the stage a bevy of medical men, whom he endows with various grotesque foibles which suggest those of actual

living types to the found any day in the neighbourhood of Harley Street. Medical men will recognise the kind of specialist who believes in the removal of the "nuciform sac" for the relief or cure of every human malady. They will also recall poor and sometimes able practitioners in mean streets who have been fellow students of Court physicians and titled leaders of the profession. What they will not recognise, however, is Mr. Shaw's absurd travesty of the opsonic index. As a burlesque writer Mr. Shaw has to cast his net with an exceedingly wide sweep, but surely never dramatist landed a queerer fish than in this instance. As a matter of fact, to grasp the intricacies of the opsonic index demands a wide and highly technical scientific knowledge, and in its present form it is neither understood by one medical practitioner in a hundred nor applied by one in a thousand. When a non-medical dramatist, therefore, fixes on the opsonic index as the key to his plot he is likely to get into difficulties. To cut a long story short, a newly knighted physician, Sir Colenso Ridgeon, can treat only a limited number of patients in his clinic. He is persuaded by a lady to give the preference to her supposed husband, a clever, artistic scamp. The dramatic situation here presented is intense—but it is none the less impossible—and we venture to question its admissibility in any rigid scheme of dramatic art as the motif of a drama. Comedy writers, however, assume a good deal of licence in that and other directions, but if we ourselves stray into the fields of dramatic criticism we are likely to fall into morasses more entangling than those which are so boldly confronted by our versatile dramatist. His motto, indeed, might aptly be the sentence put by one of the greatest writers of his age into the mouth of one of his characters, "*Homo sum, humani nihil a me alienum puto.*" The latter part of the play somewhat loses its hold upon the audience, but we should advise all medical men, if possible, to make a point of seeing this extremely clever and humorous skit upon their own profession.

A Penal Case.

One of the penal cases before the General Medical Council last week was that of a Dr. H. C. Juler, who was summoned to appear and answer a charge that in July last he had been convicted of an act in violation of public decency in Hyde Park. We know nothing of Dr. Juler or of the details of the case, but his record shows him to be a well-qualified man. He is an M.D. of Aberdeen, an M.R.C.S. and L.M., England, and an L.S.A. of London. But as Dr. Juler was qualified in 1853, he must now be over seventy, and probably nearly eighty. Now, is it likely that a man who has passed an outwardly blameless life and attained this advanced age would suddenly commit the act of a guttersnipe without the operation of some pathological cause? These cases are unsavoury at the best, but medical men are well aware that old gentlemen not infrequently commit acts of an indecent character when they are the subjects of senile mental decay or of local troubles of the urinary organs, and it is neither rational nor merciful to regard them as other than the victims of morbid manifestations. Medical men strive to get courts of justice to take a scientific view of persons thus afflicted, sometimes successfully, but often unsuccessfully; but we do expect that a court of medical men will view them in the proper light, and treat them as subjects for medical care and not for penal discipline. The Medical Press and Circular always stands for the highest code of conduct among medical men, but as the Council did not have Dr. Juler before them we fear that a cruel wrong may have been committed.

The passing of Systematic Lectures in Medical Subjects.

Some years ago, when a Joint Committee of the Royal Colleges in Ireland was considering proposed alterations and reforms in their curriculum, a proposal was brought forward by the representatives of the Royal College of Surgeons that systematic lectures in medical and surgical subjects should be abolished and their place taken by more careful and extended clinical teaching. We believe that eventually the Committee approved of the proposal so far as it affected those subjects for which the College of Surgeons was responsible, but that when the Committee's report went back to the College, the Council disapproved of that portion of it. Since then the matter remained in abeyance, so far as any definite action was concerned, until the present meeting of the General Medical Council, when Sir Thomas Myles, the representative of the Royal College of Surgeons of Ireland, brought forward a motion to the effect that it should be remitted to the Education Committee "to consider and report how far it might be possible to dispense with the customary attendance of students on systematic lectures in the medical schools." A keen and interesting debate followed, with the result that seven members voted for the motion, and seventeen against it, while five members declined to vote, and four were absent. This result is very much what one would expect. A proposal of so revolutionary a nature, even if it is admitted to be desirable, could scarcely expect a greater measure of support on its first enunciation. There is no doubt that the more clinical teaching and the more practical work a student can receive and can perform during his course the better, but we are inclined to doubt if the existing opportunities for such teaching and work are sufficient to occupy the student's time. We doubt if the addition of the fifth year of medical study, in which a student was supposed to be free from the trammels of lectures and to devote his time entirely to practical work, has accomplished the wishes of its originators.

Mixed Boarding Schools.

There are a considerable number of people who think that the advantages of co-education outweigh the disadvantages which are apparent in the system. The mingling of the sexes, it is contended, tends to soften and render chivalrous the rough, uncouth nature of the young male, and to steel the shrinking female nature against the timidity by which it is beset. So far these enthusiasts have not made much progress in this country, and it is doubtful if they will. We are at one with them in condemning the vices which are too prevalent at public schools, but the obvious remedy, namely

vigilant and prescient administration, is seldom tried. The pride of the English public school system is the neglect of masters to look after the boys during their spare time, the boast being that youngsters thereby attain to early independence of character. That blessing is a doubtful one, and it is doubtfully achieved. Independence is a fine characteristic, but independence of moral and social laws, if cheaply bought, is heavily paid for afterwards. But we hardly fancy that the introduction of young girls into public schools is likely either to diminish vice or to transform boy nature. Indeed, we did not know that co-educationists intended more than that children of the two sexes should meet at day-schools, but the Rev. Cecil Grant has lately been appointed headmaster of a school at Harpenden where girls and boys are both to reside and be educated. Mr. Grant has many backers among headmasters and headmistresses, and we shall watch his venture with interest. Perhaps in the near future we shall have mixed teams of young "Springboks" ready to contest the honour of the old country.

Medical Inspection of School Children.

While the Education Bill is in the melting-pot no one can predict in what form it will eventually pass into law, or what shape its provisions may take. The only unopposed clause was that providing for the medical inspection of school children, and medical men may sincerely congratulate themselves that their teaching on this subject has so thoroughly permeated the classes and masses that all parties are agreed as to its necessity. But it must be confessed that there may be rocks ahead if the clause is made compulsory; after one or two changes, it now stands that local authorities *shall* make inspections, and though all looks fair at present, there is little doubt that in the future there will be squalls when the clause comes to be administered. In Dunfermline, where the Carnegie Trust provided, among other good things, a medical man to look after the physique of the school children, there has been objection on the part of a good many parents, and though the opposition is now disappearing it shows that the parents of British children are ticklish people to deal with. It would be a thousand pities if the compulsory nature of the examinations put up the backs of any body of people and tended to create opposition to this beneficent work. We believe that the value of medical care and inspection will soon be apparent to all, and will make itself popular on its own merits, but it is probable there would be more political sagacity in making the examinations permissive than in making them compulsory. Medical men wish to be recognised as the parents' friendly advisers, not as their official inspectors.

Food Preservatives.

On November 29th a conference was held in the Lecture Hall of the Incorporated Institute of Hygiene to consider the subject of preservatives in food, their use and abuse. The meeting was held at an opportune moment, for it is perhaps too much the fashion to imagine there is only one side to the question. There are many reasons that make it imperative to use preservatives in the transit and storage of some kinds of food. Alcohol and sugar, used for the purpose, so long as consumed in reasonable quantities, are a source of energy in the body and must therefore be regarded as foods. Salt is normally present in the body, but whether its presence in quantity is harmless may well be questioned. These and many other interesting points were discussed by the president, Professor Tunnicliffe, who remarked he would dread to think what would happen if they prohibited the use of saltpetre, which was neither a normal constituent of the body nor a source of bodily energy. He also alluded to the chemical preservatives such as salicylic acid, formic aldehyde, and so on. Professor Thresh claimed that public regulations should be made forthwith as to what preservatives might be used, with full details as to notification, amount and other particulars. A most interesting discussion followed on this highly important and practical subject.

The Brighton "Powder Case" Sentence.

The verdict in the notorious Brighton quack medicine vending frauds is calculated to astound the plain man who asks for equal justice all round. Here was a man, posing under various aliases as a clergyman, and carrying on a huge trade in worthless nostrums. He cheerfully undertook to cure any disease under the sun, and treated all applicants alike with powders composed of bromide of potassium and bicarbonate of soda. This physic, costing a few pence, was sold at extortionate prices to customers. The trade of this scoundrel, therefore, was nothing short of a cool, calculated, wicked and injurious fraud. He had carried on a huge advertising business for years, and must have amassed enormous profits. Yet the result of the trial is that the father was sentenced to three months' hard labour, while a similar charge against his son was withdrawn. At every Sessions and Assize Court in the Kingdom prisoners are sentenced to years and years of imprisonment for far less serious offences. The learned judge congratulated the Crown on their recent policy of undertaking prosecutions of the sort. After this exposure it is clear that any newspaper receiving advertisements in future from this scoundrel will be incurring a grave responsibility, and technically will probably become in the eyes of the law *particeps criminis*.

Slate Quarrymen and Cardiac Dilatation.

THE question of trade diseases is obviously one of importance to the community. Of late years there has been a growing tendency on the part of the State to inquire into, and, so far as possible, to limit the margin of industrial wastage from that cause. Fortunately, medical science has, of late years, made vast strides in the pathology of this wide and varied group of maladies. In not a few instances, however, our knowledge is scanty and inadequate, while in other directions it seems likely that sources of mischief are still unsuspected. An old and valued correspondent draws attention to a discussion upon cardiac dilatation due to working in slate quarries, a subject that was first noticed in THE MEDICAL PRESS AND CIRCULAR in June last. He has been

requested by Mr. Herbert Samuel to give evidence before the Committee of the Commons appointed to enquire into and report upon disease of an industrial origin, as apart from accidents. Having had some experience of Parliamentary Commissions, he has for the present declined to come up to London to give evidence. The subject, however, is of great medical interest, and we trust that he may be induced to bring it prominently before the profession through the medium of our columns. There must be many Welsh practitioners capable of throwing a deal of valuable light upon the question, and it need hardly be said that any communication of the kind would command a good deal of attention at the present moment, when the unsettled conditions of the Workmen's Compensation Act are so prominently before the public.

Pouring Cold Water on the Bath.

"Are we too clean?" is a subject that might be suggested for profitless discussion in the columns of our lay contemporaries when hard up for a sensation. It might even be used as an additional argument against the Soap Trust, and no stick is too bad to beat a dog with. The anti-soap party, however, would find a powerful ally in a Dr. Cerboni, who has lately been making strong remarks about the folly of washing. This gentleman, who has reached the ripe age of seventy-five and has never had a bath in his life, is filled with contempt for the insensate practice of keeping the skin clean. "To wash," he says, "is a proceeding repugnant to nature and injurious to health." Regular washing in his opinion exposes the body to cold, reduces the vitality, brings on premature death, and makes the skin dry, harsh, and brittle. Dr. Cerboni argues that by not washing the skin soon acquires for itself a "comfortable, natural deposit," which not only allows the skin to perform its natural function of secretion without let or hindrance, but also provides a culture-medium wherein beneficent germs breed and render harmless the attacks of pathogenic ones. Now a medical man who has reached the mature age attained by Dr. Cerboni can speak from experience if not with authority, and if he has faithfully followed the precepts he enunciates, there can be little doubt that he will make certain converts. But the climate, or the circumstances, or both, in Great Britain are different from those of Italy, and we hardly imagine that he will attract many followers in this country, outside the boundaries of "little Italy." Health or no health, the Britisher likes his tub, and it is an opinion, or perhaps a delusion, prevalent over here, that he is all the better for it.

Pharmacists for the Army.

Surgeon-General Evatt, with characteristic energy, is pursuing his campaign in favour of the appointment of expert pharmacists to the Army for service in time of war. There is no doubt that it is of importance to the efficiency of the soldier that the medicines ordered by the medical officer should be supplied as ordered, and if there is at present no guarantee of this, then the matter ought speedily to be set right. As Surgeon-General Evatt maintained in his recent lecture before the Pharmaceutical Society, it is not a question principally affecting the pharmaceutical craft, but one affecting the efficiency of the Army. We are not concerned with the details of Surgeon-General Evatt's scheme, which may or may not receive acceptance, but his general principle is, we believe, sound. The infusion of a number of skilled pharmacists into the Royal Army Medical Corps would doubtless give the officers of that Corps a readier confidence in their dispensers, and would thereby diminish an irksome responsibility, leaving them free for more important duties. The details of the scheme, however, must be carefully thought out, and must receive the criticism of experienced Army medical officers.

Hospital Reform.

It is to be hoped that some good will result from the Conference on Hospital Reform which is to be held this week on the initiative of the British Medical Association. For the past couple of years this body has interested itself in the matter, with the result that a joint committee consisting of hospital managers and of members of the medical profession has been sitting, and has been endeavouring to obtain the adoption of certain general principles of reform by hospital boards throughout the country. It is true that the most important principles have as yet hardly been agreed upon by the joint committee, but it is well that even a start has been made. There are three main points to be considered at present in questions of hospital reform, which we hope may be pressed at the Conference this week. These are the protection of the benefits of hospital treatment for the poor, the protection of the general practitioner, and the protection of the hospital staff from sweating. If the first point be attained, the other two will follow. Of them the former is by far the more important, since it is largely by their own influence that members of hospital staffs have arrived at their present position. Had they taken the trouble, as they might have done, carefully to weed their out-patient rooms even of those obviously able to pay for treatment elsewhere, the present gigantic abuse could not have arisen.

While on a visit to Liverpool last week to open the new Cotton Exchange in Liverpool, their Royal Highnesses the Prince and Princess of Wales unofficially inspected the laboratories of the School of Tropical Medicine connected with the local university.

Dr. R. T. Halliday was recently entertained by his numerous friends at a complimentary dinner in honour of his appointment as medical officer to the Glasgow police. The chair was taken by Professor Stockman.

The condition of Dr. Lapponi, the Pope's physician, is graver. He has fever, which seems to have been caused by incipient blood poisoning.

Sir Charles Ball, F.R.C.S.I., Regius Professor of Surgery in the University of Dublin, has been appointed by the Board of Trinity College as the representative of Dublin University on the General Medical Council in room of Professor E. H. Bennett. Mr. J. W. B. Hodsdon has been selected by the Royal College of Surgeons of Edinburgh as their representative in place of Sir Patrick Heron Watson.

A CLINICAL LECTURE ON POST-TRAUMATIC NEUROSES.

By T. G. MOORHEAD, M.D., F.R.C.P.I., D.P.H.,

Physician to the City of Dublin Hospital.

THE nature and extent of the nervous symptoms and signs which may follow remotely from general injuries and from local injuries of the central nervous system itself is a subject which, while constantly coming before one in everyday practice, is one which has up to the present received but scant notice in the ordinary medical text-books. Accordingly, having had a number of patients recently in the hospital who represent a few of the many and indefinite types of post-traumatic neuroses, I have selected this subject to bring before you and briefly illustrate by examples this morning. Before we proceed, however, it is necessary, in the first place, to define the sense in which I intend to use the term. As ordinarily employed, it is limited to post-traumatic "functional" nervous disturbances, and undoubtedly correctly so; but for convenience I will use it now in a looser sense to include all the late nervous conditions which may develop as a result of injuries, whether those conditions are the result of gross pathological changes or not. My reason for doing so is that in the majority of cases the problem that first meets the physician when confronted with such a patient is the question whether the case is merely a neurosis in the ordinary acceptation of the word, or is something more; and if he is rightly sceptical, it will remain as a neurosis, at any rate in his mind, until he has got very sufficient reason to form a contrary judgment. The realisation, moreover, that this question must be answered should cause one to use every care and precaution in eliciting the history of the development of the disease, and in observing from day to day the symptoms and signs of the disease and the variations in these that may develop; while careful inquiry into the exact nature of the alleged causative injury, and into the immediate sequelæ of it, should also, of course, be made. Another reason for my use of the term is that in many cases the symptoms and signs are so indefinite that, while pointing strongly to the existence of some gross change, they still do not hang together sufficiently well and are not clearly enough defined to enable one either to locate or to do more than guess at the probable nature of the lesion. Such cases remain for all practical purposes as neuroses as far as both physician and patient are concerned, except, unfortunately, that they are less amenable to treatment than are the true neuroses, and that the prognosis must be even more guarded than usual when definite pathological changes are suspected to be present.

Although not coming within the scope of the ordinary text-books, the subject of traumatic affections of the nervous system has by no means been neglected, and in connection with it there exists a copious literature to which many writers in our own country have given important contributions. One of the early authors to point out its importance was Erichsen, who in his well-known book on so-called "railway spine," enumerated the different immediate and remote lesions of the spinal cord and its membranes that he had met with in cases of contusion or concussion of the spinal cord. Many of the types that he describes are, however, chiefly of surgical interest, and as he almost entirely limits himself to spinal cases, I need not further refer to his work, since it is principally of the cerebral manifestations that I wish to speak. To this last-named aspect of the subject an important contribution was made by Crisp English in his Hunterian lectures for 1904, and innumerable records of cases and classifications are to be found in the neurological and general medical journals of every country. Dr. English records and analyses his cases in accordance with the most prominent symptoms that they presented, and where such heterogeneous symptoms are met with, this method undoubtedly has its advantages; but as the cases that I will show you, or refer to, can all be included under a few headings, I will adopt the following, which nearly coincides with that employed by Judson Bury (*B.M.J.*, 1904, Vol. I., p. 997)—viz:—(1) Traumatic neurasthenia; (2) Traumatic hysteria; (3) Traumatic insanity; (4) Cases resembling intracranial tumour or other cerebral lesion.

Traumatic Neurasthenia.—Under this heading will be grouped the vast majority of cases that one meets with. My own interest in the matter was first awakened some four years ago by observing that many patients who had undergone operations in the hospital used to come to my out-patient department months afterwards complaining of numerous and more or less ill-defined troubles, which they believed to have first set in after the operation they had undergone, and which they themselves regarded as the after-effects of the operation. On examining these individuals, I was never able to detect any organic lesion in any part of their body to account for their complaints, and so I gradually began to group them as examples of post-operative neurasthenia, though for a long time sceptical about the possibility of neurasthenia following what in many cases were minor operations. Since that time I am continually seeing such patients, in addition to the more ordinary traumatic neurasthenics, who have suffered either from injury to the head or from general injuries, and I refer to them in order to impress upon you the fact that it is not the severity of the injury that determines the subsequent symptoms. Dr. Edred Corner has lately published a most interesting paper on "Surgical and Post-Operative Neurasthenia," in the *International Clinics* (Vol. IV., Fifteenth Series, 1906), and with almost all of what he states I am in perfect agreement. In it he points out that as far as the operative type is concerned, he himself most frequently meets with it after small operations, owing, as he suggests, to the fact that they are followed by an almost immediate return to business without any intervening period of convalescence and after-treatment. He also lays stress upon the part that the use of and dread of an anæsthetic play in the production of the condition; but it is to the last factor that he mentions—namely, the personality of the patient—that I would myself be inclined to attribute the most important part in every variety of traumatic neurasthenia. He states that it is chiefly in the educated classes that one meets with the most marked cases: but I find them also amongst the working people, and perhaps more especially in the underfed, overgrown, and essentially neurotic lads from the west and south of Ireland. The more neurotic the individual is, the more will he think and brood over his injury, or over the operation he is about to undergo, and the more surely is he to suffer eventually. This effect of the mental condition on the symptoms is also to be seen in normal individuals when the question of compensation for injury is in the balance, a fact that is well known and has given rise to endless discussion and dispute from a medico-legal point of view. The symptoms that these patients present are so many that it would be quite impossible, and, indeed, unprofitable, for me to enumerate them all, and so I will content myself with referring to some of those that I have most commonly met with and regard as of most importance. They are as follows:—(1) General loss of self-con-

fidence. This symptom is, of course, common to neurasthenia of every origin, but appears in the type I refer to to be combined with a peculiar feeling that it is quite useless to return to work or business because the patient feels quite convinced that he is unable for it, and that even when he appears to be in every way well. He is suffering, in fact, from true enervation. A recent writer in the *British Medical Journal* has wittily referred to many of these cases as examples of "ergophobia," but, though willing to admit that ergophobia is common, and perhaps natural, I am sure that many of these patients are truthfully stating what they feel, for I have met with patients most anxious to return to work, apparently physically well, and yet "nervously" unable to do so. Often, indeed, the best treatment for such is to insist on a renewal of labour, for with the strained demand upon their energies thereby invoked, a sort of Schott mechanical treatment for the nervous system is established, and leads through improving phases to recovery. The same patients will often tell you that they are ill, that they know they are ill, and yet they cannot refer to a single definite symptom nor explain in any way their feelings. They complain also of a mist over their brain, of a complete inability to concentrate their thoughts, and of a fear of impending evil.

(2) Headache. This, as English points out, may be either general or local, and of various kinds. The varieties I have most often met with are boring post-orbital pain, and a general painful feeling of pressure over the entire head, accompanied by a straining sensation in the muscles of the back of the neck. This pressure sensation is apparently most distressing, and is often the most worrying symptom to the patient.

(3) Pains in other parts of the body. These are often complained of, and are frequently of a shooting character. They are by no means confined to the region of the original injury, but may be experienced in any part of the body. No physical cause for them can be discovered, and though apparently most annoying in their persistence, they do not appear in reality to be very severe.

(4) Sweating. This may be local or general, and may exist even when the individual is gaining weight and is otherwise physically in good condition. It is accompanied by vaso-motor paresis, and this last sign is often a most important one in aiding the diagnosis. When one finds that an ordinary examination of the patient leaves a series of red marks wherever the skin has been touched, suspicion that the case is a functional nervous one should at once be aroused. As an occasional result of this vascular asthenia, intermittent albuminuria may be met with.

(5) Increase in the superficial and deep reflexes is almost invariably present, especially an increase in the plantar reflex and in the knee jerk. Often some variation will be found from week to week, but the exaggeration may persist unaltered for years. The deep reflexes of the arm are also usually well marked, and as a part of the general irritability of the muscles one notices that the patient has a tendency to do things in a jerky manner.

(6) General irritability of the temper and changeability is often met with, but more commonly, I think, in brain workers than in those engaged in manual labour. Under this heading I may also mention the undue sensitiveness to alcohol and tobacco which develops, so that individuals who had previously been heavy drinkers may be compelled to give up alcohol altogether, because even the smallest amounts lead to extreme mental confusion, and even delirium. This symptom is often regarded as pathognomonic of neurasthenia, and is certainly a very constant one.

(7) Various disturbances of the special senses are met with, but the only two that I have myself seen with any frequency are neurasthenic asthenopia and tinnitus aurium

The following selected cases will illustrate the subject:—

M. R., æt., 24, a bricklayer by trade, was admitted with the following history: Five years ago, while at work, he was struck on the head by a falling plank, and was rendered unconscious. He was brought to hospital, where he quickly recovered without further symptoms developing, and was discharged in a couple of days. From that date, however, he has felt totally unfit for work, though on one or two occasions he has sought employment and has done light work for a week or two. He constantly suffers from diffuse and violent headaches, from a general feeling of weakness, and from irritability, and states that he is quite unable to touch any form of alcohol, as even a very small quantity makes him wildly drunk. At present he is suffering, in addition, from pain in his left lumbar region, which, as you will notice, is so excessive as to make him wince when the skin is lightly touched, and yet, when his attention is withdrawn, deep pressure is easily borne. You will notice that his general appearance is healthy, and that nothing abnormal can be made out in the form of scars or depression on his head. The vaso-motor nerves are evidently wanting in tone, as the skin flushes up after very slight irritation. The pain in his left lumbar region shoots downwards into the front of his thigh, but here also is more superficial than deep. Below the left knee he is this morning completely anæsthetic, and his left plantar reflex is absent, while the right reflex is exaggerated, as are both knee jerks, and also the supinator reflexes in his arms. The vascular, pulmonary, and other systems of the body are apparently quite healthy. This patient has been attending the hospital on and off for the last eighteen months, and all the above symptoms are liable to great variation. He has at times some albumen in the urine, but no casts. On account of the albumen I for a time thought that he might be suffering from some renal lesion, but X-ray examination and examination under an anæsthetic revealed nothing abnormal, and I now know that the lumbar pain may be present one day and gone the next, and that the albuminuria also, though more persistent when it does appear, is transitory. The last fact about him that I need mention is that his field of vision is somewhat contracted, and, according to the hospital notes, has been so for about three years. Many would regard count of the presence of the anæsthesia and rigidity, count of the presence of the anæthenia and rigidity, but from the general aspect of the case I prefer to consider it here.

Another typical case is this man, T. D., with whom most of you are familiar. He was admitted at first to the surgical wards with fractured ribs, and later came under my care with mild traumatic pneumonia. He has now been out of hospital for more than six months, and has gained a stone in weight, but he has begun to attend the dispensary, complaining of headache, dimness of vision, pains in the legs and shoulders, and at times in the chest. As you notice, he has got a well-marked tremor in the muscles of his arms, his patellar and supinator reflexes are exaggerated, and his plantar reflexes are excessive. Lately, also, he has begun to sweat very abundantly on the least exertion. The most complete examination fails to detect any pathological change in any of his viscera, and yet, though most anxious to do so, he feels absolutely unable now for work, and his symptoms are getting worse instead of better. He in fact returned to his employment soon after leaving hospital, and it is just within the last couple of months that he has again abandoned it.

Into the treatment of this class of case I do not propose to go, further than to say that the prolonged use of tonic drugs, with good feeding and possibly a month's complete rest at a convalescent home, bring about a cure in the majority of patients, provided they are seen early enough and can afford the rest. In cases of long standing and in the severer varieties, the prognosis is always doubtful, and the course of treatment will seldom be shorter than a period of twelve months.

Traumatic Hysteria.—This is, in my experience, a much rarer condition than the preceding, though Knapp (*Brain*, 1897) finds it even more commonly than neuras-

thenia. Much, however, depends on the distinctions that the observer forms in his own mind between the two different states, for they undoubtedly tend to merge into one another, and, as Michell Clarke points out, it is especially in traumatic cases that a combination of the two diseases (hystero-neurasthenia) is most often met with. The symptoms do not differ from those of ordinary hysteria, and consist of a general condition of emotionalism, together with occasional hysterical fits, and of numerous objective and subjective phenomena, such as localised paralysis, contractures, patches of anæsthesia and analgesia, hysterical joints, and the like.

The patient that I now show you is a good example of recurring hysterical fits apparently taking their origin from a severe concussion of the spine. As you see, he is apparently a healthy young man, and is aged twenty-one. The history that we have obtained from him and from his friends is as follows: He was perfectly healthy in every way until about two years ago, when, after a fall from a height of some feet, he was admitted to some hospital and was treated for what he was told was "spinal concussion." He states that at the time he completely lost power over his legs and sphincters, but as complete recovery took place within less than a week, we may assume that no very severe organic lesion can have been present. We may perhaps suppose that some ecchymosis of the spinal membranes and cord existed, but even these cannot have been very extensive. He soon returned to work, but ever since then he has been subject to attacks of the nature that I am about to describe, and of which we have seen several during the last few days. The attacks come on at intervals, and between them the patient attends to his ordinary work, which is that of a commercial traveller. As one of the prominent symptoms is pain of an anginoid character in the region of the heart, I may also mention the fact that the patient neither smokes nor drinks, and has been very temperate for some time in his use of tea. He was admitted here a few nights ago, having been brought by the ambulance, with the statement that he had been found sitting on a doorstep and crying out with agony. On admission he complained of a severe bursting sensation in the heart, and his face bore every evidence of the existence of severe pain, being covered with sweat and ashy grey in appearance; the neck looked somewhat swollen, the pulse was moderately rapid and full, and the respirations were 26 to the minute. He was moaning and screaming, and tossing himself about, and yet practically nothing abnormal could be made out to account for his symptoms, except that pressure over the left iliac fossa caused an exaggeration of them, and that his knee jerks were exaggerated. The usual remedies for angina pectoris were at first administered by the resident staff, but without giving relief; the symptoms, however, gradually disappeared, and the attack was followed by a copious outflow of light-coloured urine. As I have already stated, the attacks have been repeated on three or four occasions during the last few days, and I have learnt that exactly similar seizures have been observed in this patient in other hospitals. The question of malingering, of course, has here to be considered, but it is hard to see what such a patient, who is in fairly good circumstances, could gain by malingering, and his whole attitude and appearance, both in and between the paroxysms, is against this view. He has now been put on ordinary anti-hysterical treatment, and is apparently improving.

A somewhat similar case has just left the hospital, in which the hysterical outbursts were accompanied by severe pain in the left loin and inguinal region, and in which also there was a history of concussion of the spine. Under the application of Corrigan's button and the use of a mixture containing valerian, the symptoms rapidly improved, though I have little doubt that they will again recur.

Traumatic Insanity.—The influence that trauma exerts in the production of insanity is still a matter of dispute, some maintaining that it may be the direct exciting cause in an individual not in any way predisposed to mental disturbance, while others prefer to regard it as a merely additional factor in accelerating the onset of an attack in one who was already predisposed to, and, in fact, fated to become insane. That it does often follow trauma, particularly severe head injuries in which there is reason to believe that contusion of the brain has occurred, is, however, undoubted, and that it may also follow it so closely as to suggest to the ordinary observer that there is a definite causal relation in the sequence must be admitted. There is no definite type of traumatic insanity. Any of the main forms of mental aberration may be met with, but perhaps mania is more often seen at the beginning than any other type. The patient whom I showed you last week in the surgical wards has since developed maniacal symptoms, and has, in consequence, been removed to an asylum, and though I cannot, therefore, again introduce him directly to your notice, it will be no harm to recall some of the symptoms that he presented some days ago. He was, as you will remember, a man aged 33, who was admitted about two months ago, after a fall of 34 feet. It was stated that he struck the ground on his left side, and became immediately unconscious. On admission he was still unconscious, and had several contusions of the scalp, had two ribs broken on the left side, and his left forearm fractured. Soon after he had been put to bed he had several mild convulsive attacks, which involved his entire body with the exception of his face, but these ceased after half an hour, and left no paralysis. The unconsciousness lasted about 36 hours, and then the patient began to improve, and soon became able to talk and to move himself about in the bed. His sphincters, however, remained relaxed for about a month, and he has all along had an increased knee jerk on the right side, and also a slightly marked ankle clonus on the same side. He never quite regained his mental faculties, but appeared to be confused in his memory of events that took place before his accident, and of the accident itself he has never had any recollection. He sometimes also failed to understand the simplest questions, while at other times he was fairly intelligent. Since his accident he appeared to lose all definite sense of time. While in this state a few days he suddenly developed symptoms of acute mania, without any change in the physical signs taking place, and had to be removed to an asylum. Prognosis in these cases is always difficult, but the absence of any paralysis, or, indeed, of any signs pointing to extensive organic lesions is undoubtedly in this patient's favour. That the trauma was related to the insanity I think you will readily admit.

Cases Resembling Intracranial Tumour or Other Cerebral Lesion.—It is in this class that most caution must be exercised before allowing that the trauma has really been a causative factor in the case. Many individuals like to refer their symptoms to some definite injury, and may, indeed, be convinced that their reference is correct, without the real existence of any reason for it. One will, of course, not classify in this group those cases in which an obvious lesion of the central nervous system has taken place at the time of injury and has left permanent results, but rather those cases in which the nervous symptoms have appeared some time later, and while in some, such symptoms will point conclusively to a definite lesion in a definite part of the central nervous system, in a far greater number of examples it will be impossible to locate or form any definite conception of the change that has taken place. Several different types are described, such as traumatic epilepsy, late traumatic hemiplegia, and others, but it is unnecessary to enumerate them further. The actual pathological lesions that have been found are also most various, and include localised cerebral sclerosis, localised softening, thickening of the meninges, cysts of the meninges, and numerous other conditions.

The first case that I show you is a rather puzzling example. He is a man, æt. 45, who was admitted to the hospital some six weeks ago, with the following history: He had always been perfectly healthy till

about a month before admission, when he met with a bicycle accident, and got a severe shaking and a blow on the head. After the accident he made his way home and went to bed, feeling rather stunned and confused, but next morning he got up and went to his work as usual, and continued at work for about three weeks. During those weeks he suffered from constant headache, and complained on one or two occasions of not seeing properly. His employer also noticed that his gait was somewhat staggering, and that his hands were constantly shaking. These symptoms getting worse, the patient stopped work for a day or two, and then came into town to consult a doctor. On his way back his headache became very severe, and so he went to bed at once on getting home, and was found in bed in an unconscious condition some hours later. He was brought here the next day, and then was partly conscious and able to answer questions, though only in a confused and hesitating manner. He was passing everything under him, but was not otherwise paralysed, and could move his arms and legs quite freely. All his deep reflexes were dulled but present, and his pupils re-acted normally to light. The urine was quite normal, and the other symptoms of the body equally so. An examination of the retina a few days later showed early optic neuritis. Since his admission he has gradually improved to the state in which you now see him. He is at present able to walk about the ward quite easily, and talks pretty rationally, though he has not quite recovered his memory. The optic neuritis is still present, but not so marked as it was a fortnight ago; headache is sometimes complained of, but this symptom is now disappearing, and on the whole it looks as if complete recovery would take place.* The patient, I may add, persistently denies having ever had syphilis, and as anti-syphilitic treatment did him more harm than good, I am inclined to accept his statement as correct, and to believe that the trauma was the entire cause of his attack. What the exact lesion is it is difficult to imagine, but one may suppose that the attack was one of what is called "late apoplexy" following injury, and in which a hæmorrhage has taken place from a damaged vessel. The hæmorrhage, however, must be in an unusual situation, inasmuch as no motor or sensory disturbances have at any time been present.

The second case is, I think, undoubtedly one of localised sclerosis in the neighbourhood of the posterior part of the right internal capsule. He is, as you see, a man of about 60 years of age, and was admitted here for bronchitis. He was also in the hospital about a year ago suffering from the same disease, and it was at that time noticed that his left knee jerk was absent, his left leg was somewhat weaker than the right, and that he had complete anæsthesia over the greater part of his left leg and thigh. His left arm was also much weaker than the right, and the tone of its muscles increased, while, in addition, the patient was suffering from well-defined left hemianopsia. He gave us at the time a very distinct history of injury to the right side of his head some ten years ago, and says that since that time he has occasionally felt his left side to be weak, and has fallen once or twice to that side. I regarded the case at first as being most probably one of cerebral tumour, but I have now changed my view in consequence of the favourable change in the symptoms that has occurred, and look upon it, as I already stated, as a case of small localised sclerosis. At present the hemianopsia is present as before, but no optic neuritis has developed. His left arm is still weak, but his left leg has regained its strength to some extent, and a distinct though feeble knee jerk can be obtained. The anæsthesia has also gone, so that, on the whole, there has been a distinct amelioration.

The third and last case that I will bring before you is a man, æt. 51, who states that he fell a distance of 24 feet some three years ago, and was rendered unconscious for eight hours. He was detained in a hospital for a couple of weeks at the time on account of broken ribs and general bruising, but says that he had no paralysis. On returning to his work, he noticed that his right arm and right leg used to shake, and the shaking has gradually become worse till he has arrived at his present condition. As you see, he is now suffering from a sort of continuous clonic convulsive movement of the muscles of his right arm and leg. Both superficial and deep reflexes are increased on the right side, while his left side is normal. Sensation is perfect on both sides, and in other respects he is quite healthy. This patient has only just come under observation, and so as yet I have not fully made up my mind as to the lesion present, but I think it extremely likely that it is in the motor area of his left cerebral cortex, and that it may be possible to do something to relieve him.

In concluding, now, gentlemen, let me express the hope that I have impressed upon you the importance of trauma in affections of the nervous system. I fear that my necessarily brief and cursory account of the subject and of our cases may have failed to bring to you that conviction that I feel myself, but, if so, I would urge you to examine and think over such cases as you may yourselves meet, and then I think you will soon share my views. Of treatment I have said nothing, because to attempt to do so would have occupied almost all my time, and, indeed, as each case is a law to itself, and must be individually studied and treated, I could only have enumerated a number of details without laying down many general principles. Remember, also, that these cases need treatment. The neurasthenic is the most miserable of men, and yet he is frequently neglected even by his medical adviser, when much might be done for him by an intelligent appreciation of his symptoms and a carefully thought out plan of cure. Remember, also, the existence of these cases when you are called upon to treat individuals who are suffering from even slight concussion of the brain or cord. Very frequently the worst ultimate symptoms are found in the cases that originally were the least serious, and there is little doubt that this is to be attributed to the original want of adequate medical treatment and of rest.

(a) Since writing the above, the patient has further improved, and has been able to return to his occupation. The discs are still hazy, but nothing more.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The Lecture for next week's issue will be by William Taylor, M.B. Dub., F.R.C.S., Surgeon to and Lecturer on Clinical and Operative Surgery to the Meath Hospital, "On Cholelithiasis."*

ORIGINAL PAPERS.

TWO CASES OF CEREBRAL SYPHILIS WITH SOME REMARKS ON "TERTIARIES" AND THE TREATMENT OF SYPHILIS IN GENERAL.

By HENRI DARDENNE, M.D., M.R.C.P.
Physician to the French Hospital in London.

Case I.—A man, A. R., æt. 30, by occupation a waiter, consulted me at the French Hospital, out-patients' department, on October 25th, 1901, for some "spots" which he had on his body. He had suffered already from the same cutaneous affection a year ago.

The history he gave was briefly the following:—After connection, fifteen months ago, he noticed four weeks afterwards a slight sore on the anterior surface of the coronal fissure. His inguinal glands became enlarged within a few days, and as by his occupation he had to walk a great deal, they soon became painful. A few weeks after he had had the sore he was troubled with sore throat and spots all over him. He also began to lose part of the hairs of his eyebrows. He took some medicine which his doctor gave him, and after about six weeks he was quite free from the symptoms and thought himself "cured." He remained thus for about a year and then, being again troubled with the same symptoms, consulted me.

On examination I noticed that he was covered with a papular rash all over the body, and quite typical in aspect, and to the touch, of a syphilitic lesion. He had some mucous patches in the throat, sides of the tongue, mucous membrane of lower lip, and anus. He was rapidly put under the influence of mercury, and within a few weeks was quite free of these secondaries.

I lost sight of him for about six months, and then he visited me again for a papular rash in both palms of the hands and on the soles of his feet.

This was more obstinate to treatment than the previous rash He was most irregular in his attendance. In August, 1903, he was admitted as an in-patient under my care. He had then great difficulty in holding both his water and fæces and had besides patches of anæsthesia on the buttock and flexor surfaces of both lower limbs, and these last were also in a slightly paretic condition. His knee-jerks were exaggerated and ankle clonus was present. His temperature was normal. His blood-vessels were sclerotic, and the tension in them high. In short, he presented all the symptoms of a spinal lesion of the nature of a gumma or arteritis. The specific treatment was at once instituted, and this in a most energetic manner. Within four weeks all these symptoms had disappeared, with the exception of a slight difficulty in holding his water and a slight patch of anæsthesia round the anus.

Then, against our advice, he left the hospital, stopped all treatment as he thought he was being treated wrongly, and went to Italy to take a course of baths and massage. He came home after about four months, feeling much better in every respect. In August, 1904, he was found partly unconscious in bed, and paralysed on the right side. He was then taken into a general hospital. He visited me in November of the same year. His mental capacity seemed diminished, his right arm quite paralysed, rigid and contracted, his gait dragging.

The ultimate prognosis of such a case is very gloomy. Sooner or later he will certainly fall a victim to a parasyphilitic affection or to some coarse cerebral or spinal lesions, for his blood-vessels are now more sclerotic than when I first saw him in 1901. He will be paralysed all his life. The damage is done, and it is irreparable. It is a clear case of inadequate and insufficient treatment. Before he had the arteritis which caused the paralysis he used to suffer from intense neuralgic headache. He used to take large doses of phenacetine. Had he then taken iodides and mercury, he might have escaped the irreparable loss of his limbs, or at all events postponed this ultimate result for an indefinite period.

CASE II.—It is certainly a more instructive one, because I was able to follow it very closely for nearly four years. The patient was most anxious to get well. He used to follow his instructions most carefully and to the letter. The result has been, however, most deplorable. The case was, however, what we are falsely accustomed to call "a mild attack of syphilis," the secondaries being very benign in nature. The sanguine prognosis that two years' treatment is quite ample is a gross fallacy, and no words are strong enough to condemn such a dangerous teaching and practice. I can multiply the examples of such cases who, after that term of careful treatment, have come to me in the 5th, 7th, 10th, and 25th year, suffering from coarse tertiaries. Yet they were considered "cured"! The loss of a limb or of an organ by the unfortunate patient is the answer to such a pernicious view of the disease!

The patient was a man æt. 35. He was employed in one of the big London hotels. He consulted me on March 5th, 1901, for a pimple on his penis. His mode of living was regular; he was not addicted to alcohol. In appearance, he was most effeminate. He had on several occasions suffered from "rheumatic attacks" He had had pleurisy on the left side three years ago. His heart was slightly enlarged, and a slight systolic murmur was present. His urine was free from albumen and sugar, but was extremely acid. His blood-vessels were sclerotic and he had also huge varicose veins of both lower limbs. Judging by his arteries he appeared to be nearer 55 years than 35, as his age was. His lungs were healthy. Owing to his weak constitution he had been refused for his military service in France. He was also anæmic.

The history he gave was that six weeks before he had had connection, and five days ago he had noticed a slight sore in the region of the frænum. It was not painful.

On examination, I detected a typical hard chancre in that region. His inguinal glands were already enlarged, hard and indolent. When informed of this he felt it intensely, and told me that he was ready to follow all my instructions in order to get well. He afterwards always kept his word. Two months later he developed a slight roseolar syphilide chiefly affecting the front of the chest and abdomen. He had been walking a good deal, and as a result one of his inguinal glands had become swollen and painful. With rest in bed and fomentations, this inflammation soon subsided. He was extremely sensitive to the influence of mercury, his gums becoming swollen and tender after a few days' treatment with half a grain of the protiodide twice daily. I then used the intra-muscular injections with the biniodide salt and the "grey oil." This suited him well, and he never suffered afterwards from stomatitis. Let me once for all say that he was most regular in his attendance during the "successive courses" of treatment which he followed.

He was absolutely free from every syphilitic manifestation for nearly a year.

He had occasional sore throat, which always disappeared when he stopped smoking. However, though free from all outward syphilitic reminders, he used all the same to feel extremely weak and tired. He was never himself after he had had the syphilis. He had on many occasions to take iron, In winter I gave him cream and cod-liver oil emulsion. It was a case where the syphilis had caused both a moral and physical prostration. His usual energy had gone or nearly so, and the man was now a different one. In December, 1905, he complained of violent neuralgic headache, worse at night and affecting both the occipital and frontal regions. His appetite was quite gone. I put him at once under the influence of huge doses of sodium iodide and nightly mercurial inunctions—one drachm of the grey ointment for each friction. One has no time to lose in such cases, for, let me repeat it once more, such headaches occurring at such a period of the syphilis, and in a patient in such an adynamic condition are usually the precursors of grave impending cerebral trouble due to arteritis. Under this he felt rapidly better, and his appetite and sleep returned. He had then been under active treatment on and off for nearly three years. He went after this, in the middle of January 1906, to Brighton, and there, while walking on the sea front, complained to a friend that his left arm felt heavy and numb. His companion also noticed that his articulation had become thick, and his mouth appeared slightly drawn to one side. The patient was absolutely unconscious of his condition and he laughed at this state of things. When, on the following day, he returned to his work, his associates there noticed the same symptoms. He now complained to them that his left leg also felt "heavy." They told him to call on me, but he laughed and said it was nothing. He had now changed completely. He used to be always very anxious about the least little thing happening to him, and now he had become quite indifferent. I feel confident that timely, appropriate, energetic treatment would have again saved him from the calamity that was soon to befall him. In the afternoon of January 21st, exactly four days after he had these severe and grave warnings, he went upstairs to his room, and there, while trying to undress, he fell on the floor in a state of partial insensibility. On recovering, about a few minutes afterwards, he noticed that he was quite unable to use both his left leg and

arm. I was with him within an hour. On my arrival I found him in bed in a state of semi-stupor-like condition. He was drowsy, and had great difficulty in answering the simplest questions. His pupils were both dilated. His pulse was full and about 80 per minute; his temperature, 99° Fah.

His mouth was drawn to the left, and he complained of a certain difficulty in swallowing. His articulation was indistinct his left leg and arm absolutely paralysed, his patellar reflexes nearly gone. I came to the conclusion that he was suffering from the effects of arteritis with thrombotic formation. A colleague was called in the same evening who confirmed my diagnosis.

On the next day the examination of the fundus of both eyes proved to be negative. He was at once put under the influence of mercury and huge doses of iodide, beginning with 30 grains three times daily, and this within a few days was increased to 70 grains, his pulse being carefully watched all the time. It became soft and the circulation regular. He was also carefully fed with light but nutritious food at stated intervals. No stimulant was given. Within a week he could move his leg. His speech had become more distinct, and he could swallow much better. A week later he began also to be able to move his arm. Six weeks afterwards he left for the south of France. There was rigidity in the arm and his gait was "dragging." Now he is still in the same condition; his mental capacity much diminished and the sharp edge of his moral sense somewhat blunted. It is a most unfortunate case. He used to be a most attentive patient, and had been under careful treatment for three years. I never entertained much hope as to his ultimate welfare after he had had the severe headaches. This, as I have said, is a grave foreboding. My conviction now is that sooner or later he will fall a victim to some parasyphilitic affection, *i.e.*, an incurable form, or to some coarse cerebral or spinal lesion.

Remarks.

The proportion of such unfortunate cases is, according to Fournier, from 3 to 5 per cent., and this percentage is applicable to those patients alone who have undergone a long course of treatment, a minimum, say of three years, and, who, during all this time have led a carefully regulated life, avoiding all excesses and, above all, alcohol. With those who have been dissipated in their habits, and who have indulged in wines and alcohol, it is a quite different matter altogether. Why should this be so? Why should not all those who have been careful get well? A bad physique, a bad heredity, a manifestation of which is in being provided with defective arterial tubes, these account for the majority of such sad cases. They are born with tissues which just as they cannot resist the onslaught of a long chronic disease, can still less react in the right way against the syphilitic poison.

A sclerotic condition of the blood-vessels helps one to form an unfavourable prognosis as to the distant future of such a case, for the patient fulfils all the conditions favourable to his becoming affected later on or at any moment with cerebral arteritis. Parasyphilitic affections, *i.e.*, incurable syphilis, such as general paralysis and tabes dorsalis, affect to a very great extent individuals who from the beginning have defective blood-vessels or in whom the vessels have since become diseased. They are, then, the manifest production of bad arterial tubes.

This percentage of 3 to 5 of syphilitic patients developing late tertiaries more or less formidable is the result of statistics some twenty years old, and I feel confident that with our more modern way of treatment and our better knowledge of syphilis it could be further reduced. A long course of treatment is the only means we possess to effect this. Every treatment I consider insufficient if it has not lasted for at least four years.

For take as an example one hundred cases of general paralysis. In 95 per cent it has occurred in those who have had insufficient treatment, about a year or so, and in only 5 per cent. of those who have been undergoing a serious course of treatment lasting at least over three years.

The same result with tabes dorsalis. These figures are eloquent, and they are the best mathematical arguments for a long course of treatment.

Mercurialisation in syphilis can, as Prof. Fournier has said, be compared to vaccination. The first is a preventive, which no one can doubt, against the very vast majority of possible future syphilitic affections, but, like vaccination, it is a temporary preventive. The patient has to be "mercurialised" in order to become immune for a time more or less long against the noxious influence of the syphilitic intoxication. The treatment, as Fournier lately said, could be divided into different stages:—1st, immediately after infection, a course of treatment lasting two years, and this whether the patient is troubled with secondaries or not; 2nd, a second course of treatment lasting the whole of the fifth year of the disease; 3rd, stop again all treatment for a few years, and by the eighth or seventh year again resume treatment for another year. Such, in brief is the treatment, which of course has to be modified according to circumstances and individual peculiarities.

Personally, I consider it a perfect heresy to say that two years' treatment is quite sufficient. It may be sufficient for the present welfare of our patient, but what about his future? How many cases of syphilis have we not seen which have been treated for that brief period, and which, after five, seven, ten and twenty-five years have come to us at that stage, affected then with most formidable tertiaries costing them a limb or an organ? Yet they were considered "cured"! Their case was looked upon as a mild one!

Mild secondaries, though it may seem paradoxical to say so, are the worst cases. Once the patients are no longer troubled with any outward manifestation, they abandon all treatment. On the contrary, one with constant, troublesome and repeated secondaries, and especially the late secondaries lasting on and off for a few years, and necessitating constant treatment, has more chances to escape the tertiaries, for his syphilitic poison has been attenuated by a successive and often repeated course of treatment. The effect of a mercurial course of treatment on a patien is but temporary, and the case mentioned by Tushmann corroborates this fact to the fullest extent. It is that of a syphilitic woman becoming pregnant seven times. She is not treated at all, and each time she gives birth to a syphilitic child. She again becomes pregnant for the eighth and ninth times, she then undergoes a most energetic course of treatment, and she has after this the satisfaction each time of giving birth to a healthy child. She again becomes pregnant for the tenth time, and thinking she is "cured" neglects all treatment. She once more gives birth to another syphilitic child, who dies at the sixth month.

Finally she is pregnant for the eleventh time, undergoes a course of mercury, and again gives birth to a healthy child. This case needs no comment It looks as if it had been manufactured with the sole object of proving that a mercurial treatment has, in order to act as a sure preventive against possible syphilitic consequences, to be long and often repeated.

Again, we know that general paralysis, which is the most dreaded tertiary syphilitic manifestation, and all the more so as it is incurable, is most prevalent between the sixth and the twelfth year after the syphilitic infection. Would it not be possible to a certain extent, by a rigorous course of treatment during the fifth and seventh years to reduce the percentage of those unfortunates who fall a victim to that dreadful calamity? It would, at all events, be worth our while to try it and give the benefit of the faintest chance to our patients. It would certainly be better than telling him that he is "cured" after a course of two years' treatment. For what happens? They neglect all hygienic rules that a syphilitic should observe, and they live happy in a fool's paradise with the sword of Damocles hanging over their heads, and with the greatest possible chance of falling a victim to general paralysis

or tabes or some coarser lesions entailing the loss of a limb or an organ. Let me, then, again say that the best safeguard, the only safeguard, which a patient can possibly have to avoid these two afflictions, resides, and resides alone, in a long course of treatment which has been methodically carried out and at successive periods.

THE CAUSATION AND TREATMENT OF SOME HEADACHES. (a)

By WILFRED HARRIS, M.D.Cantab., F.R.C.P., Lond.,

Physician to the Hospital for Epilepsy and Paralysis, London, etc.

The varieties of headache considered on this occasion are the paroxysmal or periodic headaches and those dependent upon some form of toxæmia. Many periodic headaches are of the form known as true migraine, an hereditary neurosis, probably dependent upon some paroxysmal vaso-motor derangement. After describing the mode of onset and the type of headache, Dr. Harris remarked that these migrainous headaches very commonly commence in early life, and last until well past middle life, recurring at varying intervals, but usually diminishing in severity and frequency as the years pass. If gout, or tuberculosis, or other cause of frequent pyrexia supervene, the headaches as a rule disappear. The attacks often come on without any previous warning, just as epileptic attacks may do, the patient being apparently in his usual health; yet they are liable to be precipitated by the same causes that are liable to bring on a fit in an epileptic subject—namely, great excitement, late hours, a crowded room, a bout of drinking, or in women, the menstrual period. Constipation is by no means always present, the tongue is often clean at the commencement of the attack, and there is no reason to ascribe this class of case to a toxæmia of intestinal origin. If the headaches are of frequent recurrence, it is best to treat them between the attacks with bromides on the same lines as a case of epilepsy would be treated, with a mixture of the three bromides. The actual headache is often best relieved, if taken early, perferably during the stage of scintillating scotoma, by a stiff dose of butyl chloral hydrate and phenazone. Another drug that may often bring almost immediate relief is nitro-glycerine, by reducing the cerebral arterial pressure. Dr. Harris next discussed the pathology of migraine, giving reasons and describing cases which supported the hypothesis that in migraine there is a primary stage of arterial spasm, which is succeeded by vascular engorgement which directly produces the headache. He next referred to periodic headaches, which may resemble true migraine somewhat closely, and yet are less dependent upon an hereditary neurosis and paroxysmal vaso-motor spasm than upon some peripheral cause, which by its local irritant effects may set up reflexly a migrainous attack. These cases in their pathology would be strictly analogous to reflex epilepsy, such as convulsions dependent upon the peripheral irritation of worms, the irritation of a scar, etc., and he made the point that although the attack of migraine resembles true migraine, yet the peripheral cause in these cases is the most important element in their causation, and the removal of this may be followed by complete cure of the periodic headaches. Toxæmic headaches may be due to the administration of drugs, as alcohol, iron, nitro-glycerin; or may be dependent on an acute infective process, as typhoid, small-pox, pneumonia malaria, or influenza. Thirdly, it may be due to faulty metabolism, in organic disease of the liver, as alcoholic cirrhosis, or to a functional derangement of that organ. The headache that is so common a feature in gouty conditions is perhaps partly due to a deranged liver action, by which the purins and other uric acid antecedents are permitted to circulate in the blood, and partly to a faulty diet containing an excess of those bodies. Possibly excess of carbohydrate foods may also predispose to headaches, the condition lately described as hyperpyræmia.

(a) Abstract of paper read before the Harveian Society.

THE OUT-PATIENTS' ROOM.

METROPOLITAN HOSPITAL.

Arterial Tension.

By LEONARD WILLIAMS, M.D., M.R.C.P.,

Assistant Physician to the Hospital; Physician to the French Hospital

This woman, whose age is 65, has been coming to the hospital for the last three years. When she first came her chief complaint was dyspnœa on exertion. During the period that she has been coming her notes show that at various times she has had attacks of bleeding from the nose, hæmatemesis and hæmoptysis, and on the day on which I first saw her she told of an attack which had evidently been truly anginal in character. This was about a year ago, and she then complained a good deal of insomnia. On examination I found that her heart was enlarged downwards and to the left; her aortic second sound was very much increased; there was dulness over the manubrium sterni; her systolic blood pressure, as registered by Oliver's Hæmomanometer, was 200 mm. Hg.; and there was no albumen in her urine. Now, this case is instructive from many points of view. Three years ago there were not very many of us who paid particular attention to the matter of high blood pressure, and it is, therefore, no reflection upon my predecessor in charge of this case to say that when the patient first came to the hospital she presented symptoms which all of us ought in these days to recognise as typical of unduly high blood pressure. Dyspnœa, the dyspnœa of slight exertion, especially when accompanied by a history of bleeding from anywhere—whether it be from the nose, from the stomach, or from the lungs—is so suggestive of high arterial tension that it ought always to lead to the use of the manometer. It is very unlikely that in those days the manometer, even if the hospital had possessed one, would have shown the same degree of blood pressure, namely, 200 mm. Hg., which it recorded when I first saw her, but then matters had unfortunately progressed with her in the interval.

On the majority of her very frequent visits to the hospital her urine was examined, and on no occasion was any albumen discovered. This is an important point, because so many people still persist in regarding high blood pressure merely as a symptom of chronic interstitial nephritis. Such a view of the matter is, however, a ridiculously narrow one. High blood pressure occurs independently of any organic lesion either in the kidneys or elsewhere. Either by irritation of the vessel walls themselves, or by interference with the centre in the medulla, certain toxins give rise to contraction of the peripheral arterioles, and the blood pressure is thus raised. If it be not diminished organic changes are sure to take place. In the smaller arteries the degeneration which we recognise as arterio-sclerosis is particularly apt to occur. Arterio-sclerosis, as you know, is a very feminine process, inasmuch as it is a very capricious one. It may select the arteries in the renal area, or those in the hepatic or other areas, or it may be generalised. High arterial

tension will also cause damage to the larger arteries, and the aortic arch is peculiarly susceptible to the degenerative influence of high blood pressure. In the larger arteries the result is not a sclerotic, but an atheromatous, degeneration.

Now, the high blood pressure in the case of this patient, which we may assume to have been at first functional, has caused degeneration, not in her smaller arteries, but in the ascending aorta. She has a very definite dulness at the manubrium sterni, which extends rather to the right. I do not think this process will now go any further, because since I have been treating her her symptoms have very much abated; her blood pressure has fallen from what it was, namely 200 mm. Hg., to 165 mm. Hg., she has had no more attacks, and her breathing is very much more comfortable. Of course, when these cases go untreated the danger is that the atheromatous patch in the ascending aorta may yield, and give rise to an aneurysm; or that the atheromatous process may travel downwards, involving the aortic ring and the aortic cusps to give rise to a double murmur at the base; or—what is even more serious, and what we have to fear to some extent in the case of this woman—the atheromatous process may travel along the coronary arteries and interfere with the adequate blood supply to the heart, causing angina pectoris and fibrosis of the myocardium.

So far as treatment is concerned, one of the most important items is diet. The toxins which give rise to high arterial tension originate in the gastro-intestinal tract, and there seems no doubt that meat foods contribute more powerfully to the manufacture of these toxins than foods of other kinds. I always tell patients of this type that they may eat anything except what has contained blood—that is to say, I endeavour to make them into lacto-vegetarians. Milk and milk foods should form their staple diet, but I allow any fruit and vegetables, and eggs, and cheese. In giving directions to patients it is always well to make such directions as simple as possible, and the point that I insist upon is that they should eat nothing which has contained blood. Tea and coffee certainly both tend to raise arterial tension, though not for long. In bad cases, therefore, it is well that they should be avoided.

So far as drugs are concerned, iodide of potassium in large doses of from 10 to 20 grains, three times a day, certainly is of considerable value, but it is probable that its efficacy is due as much to its eliminative power as to any direct action which it may have upon the arteries themselves. It removes the offending poison and gives the vessels the opportunity of righting themselves. For any individual attack (such as this woman appears to have had) of an anginal nature, nothing can compare to nitrite of amyl. Its action is, however, very transitory, and there is therefore no use in prescribing it if we want to produce a sustained effect. The best drug for producing anything like a sustained effect is erythrol tetra-nitrate, which may be given in doses of half a grain, or even a grain, three times a day.

If the patient suffering from a condition of this kind is in a position to travel for the sake of her health, then it is most important that you should remember that she must not be sent to bracing climates, or climates of high altitude. The proper places for patient's suffering from high arterial tension, or any of its consequences, are those which are commonly called relaxing. The stations on our own south-west coasts, from Bournemouth to Land's End, offer admirable examples of the types of climate which suit patients of this class. If you can send them to a place where by means of warm baths, judiciously administered, the effects of the climate can be enhanced, then so much the better, because warm baths do these people a great deal of good. It is not difficult to understand that a warm bath, inasmuch as it dilates the blood vessels over an enormous area, gives considerable relief to the heart. Bath, in Somersetshire, Sidmouth, in Devonshire, and Bournemouth, in Hampshire, are all places where baths as well as climate may be called in to assist in the treatment of these cases, because it is necessary to insist that these cases must be treated. High arterial tension may leave its mark upon the smaller arteries or the larger arteries, but, if it be not relieved, it inevitably leaves its mark upon the heart itself. The central organ must get the blood to the periphery, and when the arterioles are contracted, its work is very largely increased. It will put up with this increased amount of work for a long period, but after a time, underfed and overworked, it bends and not infrequently breaks.

The main object, then, to which treatment must be directed is to relieve the strain on the heart by dilating the peripheral vessels. Do not, I beg of you, make the common mistake of meeting this difficulty by endeavours to stimulate the heart. If you will relieve its burden, the central organ will right itself. If you do not relieve its burden, then, by giving digitalis and its congeners, you are only whipping the tired horse and hastening its inevitable collapse.

OPERATING THEATRES.

GREAT NORTHERN HOSPITAL.

Operation for Pes Cavus.—Mr. Peyton Beale operated on a man, æt. 22, complaining of very marked pes cavus in both feet; there was a certain amount of talipes equinus also present. The patient was a ship's foreman, and he stated that the deformity had been gradually coming on during the last three or four years. On examining the feet it was evident that the plantar fascia was exceedingly tense, and that as far as the cavus condition was concerned this only was responsible. In walking he could put his heels to the ground, but in doing so complained of a good deal of pain in the soles of his feet. The legs were very carefully examined in order to ascertain if there was any tonic contraction of the calf muscles, but nothing of this sort was to be found. The region of the sciatic nerve was also carefully investigated, but nothing could be found which could in any way cause irritation in any part of that nerve. The following operation was performed:—The house surgeon having extended the foot and flexed the ankle as far as possible, a sharp-pointed tenotomy knife was introduced into the sole in five or six places, and the tense bands of the plantar fascia freely divided. When this was done there was a very marked improvement in the form of the foot. A dressing was applied, and the foot was put up on a back splint with a right-angled footpiece, so made that the foot was kept in a position of marked inversion, but at the same time at right-angles to the leg. It was intended that this should be kept on for ten days, and that the feet should then be put up in plaster of Paris. Both feet were operated on and treated in the same manner. Mr. Beale said that there was nothing in the history of the case to account for the condition. He had seen more or less similar cases before. In one he remembered there was a neuromatous tumour close to the point where the sciatic nerve divided, and in another there had been a large gumma in connection with the deep fascia of the leg between the gastrocnemius to the soleus, which had led to extensive cicatricial contraction in both those muscles. In these cases, of course, only one foot was affected. He said he considered it wiser to leave the Tendo Achillis for the present, and if he found it necessary to partially divide it in order to secure better position for the foot, he should partially divide the Tendo Achillis later on. He remarked that whenever he used a back splint with a footpiece he always had the footpiece so fixed that the foot was applied to it in a position of marked inversion, and since he had adopted this plan he found that the patients never complained of any discomfort in the foot while the splint was being used.

TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND

SECTION OF OBSTETRICS.

President, R. D. PUREFOY, M.D., F.R.C.S.I. Sectional Secretary, HENRY JELLETT, M.D., F.R.C.P.I.

MEETING HELD FRIDAY, NOVEMBER 16TH, 1906.

The PRESIDENT (Dr. R. D. PUREFOY) in the Chair.

SIR WILLIAM SMYLY showed a fibro-cystic tumour of the broad ligament weighing 13¼ lbs. He said that such tumours must be rare, as this was the first he had met with.

Sir ARTHUR MACAN asked whether the fluid from the tumour coagulated on being allowed to escape. The feeling of fluid in the tumour was an extraordinary one.

The PRESIDENT recalled a specimen shown to the Academy some years ago, on which occasion Sir Arthur Macan remarked that surely there was fluid in it. A section was made at once, and there was not a trace of fluid. He mentioned the case as showing that sometimes a tumour was met with which imparted a misleading sensation to the finger on examination.

Dr. E. H. TWEEDY showed (*a*) tubal pregnancy, (*b*) perithelioma of uterus, (*c*) fibroids undergoing sarcomatous degeneration.

Dr. ROWLETTE said that perithelioma had not been described until within the last few years. It was extremely likely that the tumour had been seen previously, but had been unrecognised. He recalled a case of tumour of the ovary presenting remarkable resemblances to that before them, which had been put before the Academy the previous year by Dr. Tweedy. The fibroid tumour was interesting on account of recent discussion as to whether such change really took place. From the naked eye appearance one would not judge it to be sarcoma, but in the broad ligament there was a mass of softened tissue which looked extremely malignant. A section from the upper part of the tumour showed not fibrous tissue at all, but a mass of sarcoma cells. A section from the lower part of the uterus showed simply a degenerating mass of fibrous tissue. The case was, he thought, correctly described.

Dr. KIDD asked if there was any method of knowing, before a section was made, whether the tumour was of a malignant nature or not; otherwise, except in extreme cases, the operator would run a great risk of infecting his patient.

Sir W. SMYLY thought that the splitting of such tumours was not free from risk. Within the last three years he had lost a patient through pus infection from an abscess which had been burst during operation.

The PRESIDENT said that the bisecting of the uterus in some cases allowed them to secure the uterine vessels and avoid injuring the uterus. He recalled a case of removal for fibroid of the uterus. There was nothing in the aspect of the uterus to suggest that it was the seat of malignant disease. The patient made a good recovery from the operation, but when the uterus was examined afterwards it presented two large foci of malignant disease. He felt that if he had bisected the uterus he would have realised the state of affairs, but he would have run the risk of infecting the patient.

Dr. TWEEDY replied.

The PRESIDENT then read his Introductory Address, in which he referred to the work of the preceding session, noticing the various communications read by the members, including papers read by Dr. Delaharpe, of Bonn; Dr. Sheill, of the Coombe Hospital; Dr. Holmes, of the Rotunda; Dr. Ashe, of the Adelaide; and Sir A. Macan, and the reports of the Rotunda Hospital—in one of which is recorded a case of spontaneous inversion of the uterus occurring in the hospital, while the patient was under observation. The theories recently adduced as to the causes of eclampsia were mentioned, and the value of the old treatment by bleeding, followed by saline transfusion, was emphasised. The views recently put forward by Halban as to the secretion furnished by the ovaries and placenta, and its influence on the genital organs of both mother and child, were noticed; also the supposed influence of luteum tissue in causing the development of hydatidiform moles, malignant or otherwise. Reference was made to three cases of accidental hæmorrhage, recently reported, all of which ended fatally, and in all of which autopsy showed incomplete, external rupture of the uterus had taken place. Dr. Savage's recent paper on "Ovarian Hæmatomata" received very favourable notice, and attention was directed to the renewed interest in, and good results obtained by, serum injections in puerperal sepsis.

REPEATED TWIN ABORTIONS AND VENTRO-SUSPENSION.

Dr. SPENCER SHEILL then read a paper on repeated abortion and ventro-suspension.

A woman, æt. about thirty years, married four years, has had four abortions, all at about the tenth week, the first one being twins. There is a family history of twins—she has twin sisters. On the 3rd of May, 1905, he curetted the patient for an incomplete abortion, when she came under his care for the first time, and at that time he made the diagnosis of acute retroflection with a fibroid, and recommended operation, as she was very desirous of having a living child. She agreed, and on the 23rd of the following June he removed a pedunculated fibroid about the size of a hen's egg, which was attached to the fundus, and did a ventral suspension. The patient menstruated normally on July 19th and August 21st, her husband being away in the country. He returned, and cohabited with her for the first time since the operation on September 1st, 1905, with the result that Dr. Sheill delivered the patient of a child, which showed every evidence of being full term, on June 16th, 1906, so that the conception must have taken place on or about September 16th, 1905—*i.e.*, sixteen days after the husband's return. But on October 21st, 1905, exactly two calender months after the last menses, the patient had a uterine hæmorrhage, and with it came away an ovum of about six weeks development. The hæmorrhage was not very profuse, and soon ceased. There was no pain, so active interference was withheld. The patient was taking potassium chlorate at this time. No further menses occurred, and on examination early in January, 1906, Dr. Sheill diagnosed a "uterus large enough for four and a half or five months' pregnancy, which might be a mole or a twin of the ovum aborted last October." With regard to the success of the operation itself, it is interesting to note that the ventro-suspension caused no pain, unusual vomiting or frequency of micturition during gestation, and that there was no dragging on or alteration in shape of the uterus other than a slight dimple at the fundus. The labour was uneventful, and the ventral scar showed no signs of weakness. A vaginal examination a month later showed the uterus to be normally involuted and in perfect position. An enlargement of the thyroid gland has been described in infants born of mothers who have been taking potassium chlorate during pregnancy with a view to prevent abortion. There was no such enlargement in the infants' thyroid in this case.

Sir W. SMYLY said he believed the displacement was a cause of complications. He approved of suspension, but many cases of retroversion—especially those which occurred after delivery—got well if treated with a pessary. He had no doubt that the living child was the result of Dr. Sheill's treatment.

Professor A. SMITH said he thought the displacement was due to the tumour dragging on the wall of the uterus. Dr. Sheill had acted wisely in removing the tumour and preserving the uterus. Of course, one could not say whether it was absolutely necessary to have suspended the uterus. He had removed fibroids from the back of the uterus, and it had righted itself after a time. Cases were well-known in which one of the causes of the displacement of the uterus was the weight of a fibroid tumour dragging on it, and he

knew of a series of cases of suspension of the uterus where pregnancy did not occur. He was a believer in suspension, but it was difficult to decide which method to follow.

Dr. Jellett said that for the last couple of years he had been doing a considerable number of radical cures of backwards displacement of the uterus, and of them five patients had been confined in hospital after operation. In no case was there any trouble. He was inclined to the belief that, after a simple ventro-suspension, if the patient became pregnant, a return of the displacement was likely to occur. He had found no difficulty in Alexander's operation, and in no case had the immediate results been otherwise than excellent. He was therefore in favour of the Alexander operation in simple uncomplicated cases of retroversion of the uterus. There were, however, a number of cases in which it was entirely inapplicable, among which Dr. Sheill's case was, he thought, included.

Sir A. Macan said the paper opened up the whole question as to whether every case of retroflection was to be operated on. They should try to settle the indications, and until this was done he preferred treatment with the pessary. He considered the Alexander operation more reasonable than fixation against the abdominal walls. When the cornu of the uterus had been fixed almost into the internal abdominal ring, if the woman became pregnant, parts which were almost touching became stretched five inches, and he confessed that it appeared very strange to him that they should go back again after such stretching. The whole question was not near solution, and he was anxiously looking to some experience that would help him to make up his mind as to what cases he should operate on, and the best method.

Dr. Ashe said it was impossible to say if Alexander's operation would be a success until one had ascertained by inspection the condition of the round ligaments.

Dr. FitzGibbon said that vaginal shortening of the round ligaments was not often mentioned, although it was easy to perform. He had seen a case two months afterwards, and the uterus was perfectly in place. By such a method an abdominal scar was avoided; but, if there had been pelvic inflammation, there would probably be adhesions between the uterus and the pelvic walls, in which case it would be necessary to open the abdomen.

Dr. Hastings Tweedy thought Sir Arthur Macan had taken a rather gloomy view of the many disastrous possibilities of ventro-suspension. It never occurred to him (Dr. Tweedy) to look forward with the least anxiety to pregnancy or labour following this operation. If a sufficient number of stitches were not placed in the uterus, a relapse would follow delivery. He thought therefore the suspension should be made by two separate sutures. One could never say that occlusion of the tubes was not present until the abdomen was opened, and for this reason he considered Alexander's operation much inferior to the ventral suspension.

Dr. Horne thought that if there were adhesions they were bound to interfere with them; but, if not, he was inclined to replace the uterus and insert a pessary, even if the woman became pregnant.

The President said that no single method could be considered free of the possibility of giving rise to complications. He remembered the case of a woman who had been operated on by Mr. Alexander himself, and who had aborted three times in the two succeeding years. It was obvious that the round ligaments might stretch and allow the recurrence of the displacement. The peritoneal adhesions which were formed in ventro-suspension might also stretch and give rise to various risks.

Dr. Sheill then replied.

The following card specimens were shown:—

Dr. E. H. Tweedy—(*a*) adeno-carcinoma of vulva; (*b*) epithelioma of vulva; (*c*) adenoma of uterus; (*d*) epithelioma of cervix; (*e*) myomatous uteri, 8; (*f*) pyosalpinx and salpingitis, 6; (*g*) ectopic pregnancies, 2; (*h*) ovarian cysts, 10.

THE LIVERPOOL MEDICAL INSTITUTION.

Meeting held Thursday, November 22nd, 1906.

Frank T. Paul, President, in the Chair.

NO-LOOP GASTRO-ENTEROSTOMY.

Mr. K. W. Monsarrat read a paper on Posterior Gastro-enterostomy, with special reference to its performance without a loop. He discussed the functional results obtained by this method, particularly in regard to the absence of regurgitant vomiting, and illustrated his paper by clinical cases.

The President stated that he had had the opportunity of seeing the condition present in three cases of gastro-enterostomy, suffering from regurgitant vomiting, and failed to find an anatomical explanation of the trouble. In these and other cases he had met with there was only one common element, and that was gastric atony. The patients were either neurotics or exhausted cancer cases, and the most perfect "no loop" operation was no bar to this cause of failure in such people. In past times and recently on special occasions he had done the anterior operation, altogether perhaps twenty times, and it was noteworthy that he had not met with regurgitant vomiting following the operation. When the trouble occurred it could be cured by entero-enterostomy, especially with partial occlusion of the ascending limb of bowel between the intestinal anastomosis and the stomach. Such an operation, however, was difficult to accomplish after a genuinely "no-loop" operation.

Mr. Thelwall Thomas said he had always performed posterior gastro-enterostomy by the "no-loop" method, and considered the anterior operation and the Y-method open to grave objections. In only one case had he observed any symptoms suggestive of "vicious circle" and it was with difficulty that he had then performed entero-enterostomy.

Mr. R. W. Murray and Dr. E. T. Davies also spoke.

SPONTANEOUS FRACTURE OF URINARY CALCULI.

Dr. T. R. Bradshaw related a case of Spontaneous Fragmentation and Evacuation of Uric Acid Calculi in a gentleman, æt. 80. Fragments had been passed at intervals extending over nearly a year. Calculi had been located previously in one kidney by the X-rays, and there had been attacks of renal colic and hæmaturia. He believed, with Prout, that uric acid calculi frequently had a radial structure which facilitated fragmentation, and that the latter was brought about by the action of healthy urine containing a minimal quantity of nitrogenous waste products. He thought that urine of this character was not common in the subjects of calculi; hence the infrequency of spontaneous disintegration. He considered that the attempt to dissolve calculi by administering alkalies was useless, and might be injurious by tending to the deposition of phosphates on a uric acid stone.

Mr. George G. Hamilton showed a patient with Erb's Paralysis caused by a fall by which the brachial plexus was in part ruptured. Mr. Hamilton remarked that only three cases had been previously reported.

THE GENERAL MANAGEMENT OF ABDOMINAL SECTION CASES.

Dr. W. Blair Bell read a paper on "The General Management of Abdominal Section Cases," in which he first discussed the personal equation of the patient, which, he said, must enter largely into all considerations of treatment and prognosis. The preparation of the patient, with a detailed consideration of the value of atropine before the administration of the anæsthetic; the anæsthetic, and the reasons for preferring ether to chloroform; together with points in connection with the technique of general operative procedures, especially in septic cases, were fully dealt with as essentials to be observed in the prophylaxis of post-operative complications and discomfort. He then described the routine post-operative treatment of a straightforward case, pointing out the value of frequent changes of posture, of early feeding with glucose solution and egg-albumin in water, and

the free use of salines by the rectum to prevent shock and thrombosis. He also discussed the treatment of the chief post-operative complications, indicating that most of them could be prevented by the methods of prophylaxis to which he had alluded.

Dr. H. BRIGGS said it was needless repetition, in any discussion on abdominal surgery, to mention the precautions and preparations which are as applicable to it as to general surgery. The results of the former illustrated the accommodating vitality and resourcefulness of the healthy peritoneum, of which the general pathologist, in more recent years, had so frequently reminded the surgeons. The Trendelenberg position was now almost universally appreciated. On the etiology and treatment of post-operative, gaseous, intestinal distension there was now as much obscurity as ever; hence we are unprepared to receive the often confused and worthless reports of therapeutical and surgical resources.

SIR JAMES BARR said that he had many years ago recommended the systematic use of Atropine before the administration of chloroform. He thought strychnine was very much abused in the present day, but that morphia, in small doses, was very valuable in all abdominal affections, and did not check peristaltic action in the same degree as was generally supposed. He was pleased to find that Dr. Blair Bell took systematic records of blood pressures, as the impression even of the educated finger was often very deceptive, especially when the pulse was of small volume. In cases of collapse and shock the life of the patient often depended on the maintenance of the blood pressure, and about the best drug we possessed for that purpose was adrenalin; unfortunately the action of the drug was comparatively evanescent, and it was very difficult to get its physiological effect except when it was injected into the veins, or, in abdominal operations, by injecting it and normal saline solution into the peritoneal cavity.

MR. THELWALL THOMAS was a warm advocate of the administration of atropine before ether. He criticised adversely the Clover type of inhaler, which compelled the patient to breathe his own putrid exhalations as well as ether.

Mr. G. P. NEWBOLT, speaking of general peritonitis, advocated rapid operating and washing out, as by this method time was saved and less damage done than when extensive dry swabbing was attempted. In some cases he regarded morphia and alcohol as of the greatest value. His experience in draining gut for distension had not been favourable, and in some cases of marked distension the patients had recovered without the adoption of this procedure.

Dr. T. B. GRIMSDALE had come to the conclusion that one had only to travel far enough in order to have dispelled and refuted all those little fads that one considered of such importance. As long as the true general principles were adhered to, the small details could be varied *ad infinitum*. If an operation was well performed, it seemed as if one could do almost anything one liked in the after-treatment. He thought the thing to aim at was simplicity.

Dr. W. FINGLAND referred to the administration of atropine before ether as a most valuable procedure, which he had adopted as a routine practice for many years. It had the effect of abolishing salivation, diminishing after-sickness, and facilitating the administration of the ether. In dental surgery it was equally valuable, as the operator had only the hæmorrhage from the extractions to deal with.

Dr. F. W. BAILEY thought that Chloroform suited some cases better than ether. Ether should be given by the open method, preferably with an Allis inhaler; as this method avoided the difficulty of salivation and reduced the risk during the operation and the danger of subsequent respiratory troubles. He generally began with chloroform in order to get complete relaxation of the muscles, which was so important in abdominal operations, and then went on with ether.

Mr. R. W. Murray, Mr. G. G. Hamilton, and Dr. T. Davies also spoke.

CENTRAL MIDWIVES BOARD.

MEETING HELD NOVEMBER 29TH.

The President, Dr. CHAMPNEYS, in the Chair.

THE first matter was the payment for training of Midwives by County Councils, and the Secretary read a question put by Mr. Bateman Hope, asking the President of the Local Government Board whether the Board had formed the opinion that it was illegal for County Councils to pay for such training either out of the county fund or out of the funds set apart for the purposes of higher education, and, if so, on what grounds.

Mr. John Burns had answered:—"It would seem to the Local Government Board to be competent for a county council to incur expenditure for this purpose in exercise of the powers conferred on them by Section 2 of the Education Act, 1902, if, after consultation with the Board of Education, it appeared to them desirable to do so. But they are not aware of any legal authority which would enable a county council to incur any such expenditure apart from these powers.—November 21st, 1906."

The Board then dealt with the recommendations of the Standing Committee. A letter was read from Dr. Swayne, of Denbigh, saying that the inability of the Welsh candidates to pass was not due to the examination being in English, but to want of practical knowledge. The Board, however, in answer to an appeal for a translation from the Denbighshire County Council, authorised such translation to be made.

The vexed question of doctor's fees appeared again in the form of an enquiry from a midwife. One doctor would not come, and another asked a two guinea fee, which, of course, the poorer patients could not pay.

In answer, the Board could only send the usual reply that they regretted inability to help.

Dr. Sergeant, County M.O.H. for Lancashire; sought information as to cases of puerperal fever occurring *the day after* the midwife left. But to this query the President decided that they could only prosecute when actual negligence could be determined during the regulation ten days.

A letter from Dr. Armstrong, M.O.H. for Newcastle on-Tyne, bore upon practically the same question—the teaching and supervision of uncertified midwives—but here again the President pointed out the Board's inability to deal with such women until 1910.

The subject of multiplying centres to meet the requirements of a small number came up again, this time from Newbury.

Dr. PARKER YOUNG remarked that the Board ought to give more attention to such appeals. Here were women, anxious to be trained, seventeen miles from the nearest centre. Dr. Thompson, a man holding high qualifications, had volunteered to teach them, and had been rejected. The other doctor in Newbury did not care to hold a class unless twelve candidates could be found. Midwives were wanted, and it was clear the Board were putting obstacles in the way.

Miss Paget was in favour, also Miss Wilson, of a Newbury centre, though Sir Wm. Sinclair and Mr. Ward Cousins who were not present, have always protested against the multiplication of centres.

The PRESIDENT thought the Board were quite right in refusing, but as Dr. Parker Young and one or two others seemed to think an injustice had been done, he agreed to a motion that Dr. Thompson should be asked to apply again for the post.

The Marchioness of Winchester, Vice-president of the Hants Nursing Association, wrote objecting to the term "suspended," saying it was derogatory and savoured of "misconduct."

Miss PAGET remarked that the term was in great disfavour in many centres.

Answer was returned that the terms "suspend" and "suspension." had definite technical meanings as laid down by the Midwives Act.

The first physician of the Cama Hospital, who enquired by letter why the Hospital could not be sanctioned as a centre, had reply that it was contrary to practice to give reasons.

The proceedings then terminated.

GENERAL MEDICAL COUNCIL.

EIGHTY-FOURTH SESSION.

First Day; Tuesday, November 27th, 1906.

Dr. MacAlister, President, in the Chair.

The President informed the Council, with regret, that he had received communications from two members of the Council, Dr. Barrs and Dr. Cocking, intimating their inability to be present during the session on account of ill-health.

The official notifications of the appointment of two members to the General Medical Council were then read by the Registrar :—

1.—We, the Royal College of Surgeons of Edinburgh, in pursuance of the power given us by the Medical Act, 1886, do hereby appoint James William Beeman Hodsdon, Esq., to be a member of the General Medical Council of Medical Education and Registration of the United Kingdom for the term of five years from the 21st day of June, 1906.

Charles Watson MacGillivray, M.D., President.

Mr. Hodsdon was introduced to the Council by Sir John Batty Tuke.

2.—We, the University of Dublin, in pursuance of the power . . . . . do hereby appoint Sir Charles Ball . . . . . for the term of one year from the 23rd day of June, 1906.

R. Y. Tyrrell, Registrar.

Sir Charles Ball was introduced by Dr. Little, and cordially received by the Council.

The President then delivered the following address :—

Gentlemen,—Let me begin by offering you my congratulations on the improved physical conditions under which you assemble to-day. The plans for the enlargement of this chamber, submitted by the Office Site Committee last May, have during the summer been carried out under its direction. . . .

Of the members who were accustomed to meet with us in the old chamber, three are missing from the new. You will allow me to say a few words about each.

Our senior member, Sir Patrick Heron Watson, *magnum et venerabile nomen*, who since 1882 has sat with us as the representative appointed by the Royal College of Surgeons of Edinburgh, retired at Midsummer after twenty-four years of distinguished service. We are the poorer for the loss of a Councillor whose grave wisdom, and whose stately eloquence upon fit occasion, were but the expression of his high conception of professional duty, and of his sterling personal character. He has received many tokens of honour from the Sovereigns whom in peace and war he served, from the university and the college which he helped to govern, and from the profession which he still adorns; he will not, I feel sure, be other than gratified by the tribute of cordial regard which in your name I venture to offer him on his retirement.

After ten years of service, Dr. E. H. Bennett has ceased to represent the University of Dublin in this Council, where his sturdy common sense and firmness of purpose were recognised by all. Those who remember his predecessor will agree that it was no easy task to follow Dr. Samuel Haughton, whose manifold experience and sprightly temper gave him a unique place in our counsels. But it will also be readily admitted that the influence and repute of his university have suffered no detriment at the hands of Dr. Bennett. He was always willing to take his share in the administrative and educational work of the Council, and he did well whatever he undertook.

Sir Victor Horsley, who was first returned as a directly-elected member in 1897, resigned his seat on October 29th, in order that the Council and the medical practitioners of England might be saved the inconvenience of a bye-election next year. But for his forethought and consideration it would have been necessary, under the provisions of the Medical Act, 1886, to hold a bye-election not only in 1907, but in every fifth year thereafter. His resignation at the present time has rendered it possible so to arrange matters that, now and henceforth, a general election of three English members every five years may suffice. The Council and the electors will properly appreciate the fact that Sir Victor has had in mind their interests in thus choosing the date at which he lays down his office. The Council certainly will not soon forget a colleague, who, after attaining high eminence as a physiologist and a surgeon, gave himself enthusiastically to the public service of his fellows, and strenuously laboured to overthrow whatever he deemed to be an obstruction to professional progress. Though we might not all share his opinions on all subjects, we could not fail to be impressed by the alertness of his mind, the acuteness of his criticism, and the zeal of his advocacy.

In place of Sir Patrick Heron Watson, the Royal College of Surgeons of Edinburgh has appointed Mr. Hodsdon, who, both as a surgeon and as a man of affairs, bears a high reputation among his professional brethren in Scotland. In place of Dr. Bennett, we welcome back to the Council an old friend in the person of Sir Charles Ball. His qualities as a colleague we already know and value.

As I have indicated, the place of Sir Victor Horsley will be filled on December 12th, by means of the general election now proceeding. For the three English seats ten candidates have been duly nominated, and for the one Scottish seat two candidates. The present directly-elected members of the Council, Mr. Brown, Mr. Jackson, and Dr. Bruce, are nominated for re-election.

In fulfilment of the wish expressed by the Council in November last, the Executive Committee has obtained the consent of the Privy Council to a modification of the regulations which have hitherto governed the method of voting in such elections. By the use of signed envelopes enclosing unsigned voting-papers, the elector is now enabled to record his vote without disclosing his identity to the enumerators, or to others who may be present during the process of counting. In other words, the method authorised by the new regulations is practically that of voting by ballot, which has long been current in parliamentary and other elections elsewhere. The Executive Committee has to thank Dr. Leonard Kidd and Sir Victor Horsley for suggestions as to practical details, which have been embodied by the Privy Council in the amended schedules.

In two other matters of importance, His Majesty in Council has been pleased to give effect to the representations of the Executive Committee on your behalf.

The petition of the British Optical Association for the grant of a Charter, concerning which resolutions were adopted by the Council on May 24th, and transmitted to the Lord President, has been refused. It is moreover understood that the Sight-testing Opticians Bill introduced in the House of Lords with a purpose similar to that of the proposed Charter has been dropped.

Another petition for a Charter of Incorporation was presented by the "National Association of Medical Herbalists of Great Britain, Limited," and was advertised in the *London Gazette* at the beginning of July. As it was apparent that the grant of the powers and privileges sought for would be dangerous to the public, and would tend to defeat the purposes of the Medical Acts, a memorandum setting forth the objections to the grant was drafted, and approved by the members of the Executive Committee for transmission to the Lord President. We have now been officially informed that in this case also His Majesty in Council has been advised to refuse the prayer of the petitioners.

The Executive Committee has had before it some additional information respecting medical qualifications in Japan other than those conferred by the Imperial University. On this subject it will report in due course to the Council. The committee has also under consideration applications from the Provincial Medical Board of Novia Scotia, and from the University and College by which medical degrees are granted in that province, requesting that in pursuance of the Order in Council of May 11th, 1906, these provincial diplomas may be recognised for registration in the Colonial List of the "Medical Register." A memorandum setting forth the course of medical study and examinations enforced by law in Nova Scotia has been prepared for the information of the committee, and will be printed with its minutes on the subject.

During the summer it was my privilege to revisit Canada, in connection with the meeting of the British Medical Association at Toronto. By the kindness of the Lord President of the Privy Council and of the Governor-General, I was enabled to meet Ministers of the Crown at Ottawa, Toronto, and Quebec, and other influential persons interested in the subject of medical reciprocity between Canada and the Mother Country. I found that in some cases misconceptions existed as to the effect of recent Imperial legislation on the question, and as to the steps that are now necessary to procure the application of the Medical Act of 1886 to particular provinces. There is reason to believe that the explanations offered in answer to inquiries on these points have been serviceable in removing such misconceptions. Indeed, from an unofficial communication that has recently arrived, it would appear that in one important province, which at present does not accept British diplomas for registration, active steps are now being taken to bring about the mutual recognition of medical qualifications as between this country and the province. It gives me great pleasure to acknowledge the courtesy which as your President I received at the hands of the Dominion and provincial Ministers, and of the university and medical authorities, in Canada. From what I was able by their kindness to see and hear of the conditions of medical and scientific education in the Dominion, I was strengthened in my conviction that nothing but good can result from a closer connection and a freer interchange between the professional schools there and here.

The four-hundredth anniversary of the University of Aberdeen was celebrated last September, with unexampled magnificence on the part of the academic and municipal hosts, and with the utmost satisfaction on the part of the guests who had been invited from all parts of the world. As many members of the Council were privileged to be present, I need not enlarge on the intrinsic interest or the perfect organisation of the ceremonies. These ceremonies culminated in the solemn opening, by their Majesties the King and Queen, of the noble buildings added to Marischal College for the better accommodation of the university, and especially of that school of medicine which in the past has so greatly enhanced its fame. I should, however, report that the Address of Congratulation, which you instructed the President and treasurers to present in your name, was very graciously received by the venerable Chancellor, Lord Strathcona and Mount Royal, and that assurances have reached us that the action of the Council herein was highly appreciated by the University of Aberdeen. The text of the address has, in accordance with precedent, been reported to the Executive Committee and entered in its minutes

During the hearing of certain cases in May, the desire was expressed that the Council should be formally notified of all cases in which medical or dental practitioners are convicted on such charges as might bring them within the operation of the penal clauses of the Medical or Dentists Act. Communications were accordingly addressed by the Registrar to the Secretary of State for the Home Department, the Under-Secretary for Scotland, and to the Chief Secretary to the Lord-Lieutenant of Ireland, asking that instructions might be given to this effect. From England and Ireland we have received replies stating that the desired instructions have been issued; from Scotland we have so far heard only that our request "will receive attention."

In certain cases that will come before you for inquiry, information received in consequence of the steps thus taken by the Government authorities will be placed at your disposal. The penal cases which you will have to consider do not, I think, raise any new point of principle; they have been carefully prepared for your inquiry by the help of the reconstituted Penal Cases Committee and of your legal advisers. One of the dental cases illustrates afresh the unsatisfactory state of the law in relation to joint-stock companies which purport to carry on professional practice.

The Bills prepared on the Council's behalf, by means of which it is proposed to remedy in some measure the existing abuses, have been communicated to the Lord President; but, acting on advice which we could not disregard, we have not attempted to submit them for consideration by Parliament during the present autumn session. Next year we may hope to be more successful in urging them on the attention of Parliament.

An important opinion from eminent counsel, bearing on the "privilege" attaching to the documents and evidence submitted in connection with the penal procedure of the Council, has been obtained, and will be submitted to you *in camera*. It may be necessary, in pursuance of the advice thus given, that you should sanction an addition to the Standing Orders relating to judicial inquiries under the Medical and Dentists Acts.

The Standing Orders respecting the inspection and visitation of examinations have been so adjusted by the Executive Committee as to embody the important principles laid down by the Council at its last meeting. You will be asked to approve the form into which the rules have been cast by the committee; and formally to sanction the issue of a revised edition of the Standing Orders, which, owing to the accumulation of a number of minor amendments made from time to time by the Council, it has been thought necessary to prepare.

The important report of the Practical Midwifery Committee has by your direction been forwarded to the several teaching and examining bodies for their observations. From a large number of these bodies replies have been received, and have been arranged by the Registrar for the information of the committee, which met yesterday to consider them. The committee will probably be able to report during the present session on the progress it has made.

The Education Committee also will have something to say on the questions remitted to it on the motion of Dr. Bruce (Minutes, May 26th, 1906), namely, what effect has been given to the proviso concerning pupilage contained in one of the recommendations of the Council, and generally what steps are taken by the licensing bodies to ensure that the fifth year of the minimum curriculum shall be devoted to clinical study. From enquiries which have been made by the Registrar it would appear that little or no use is made of the permission to reckon a period of pupilage with an approved practitioner as part of the fifth year. It will be for the Council to consider whether a proviso that is practically inoperative is worth retaining. Its inclusion among our recommendations has already given rise to misconceptions regarding the lawfulness of employing in medical practice the assistance of unqualified students who are described as pupils.

In conclusion I would say that, so far as can be foreseen, the business on the programme will probably be compassed by the end of this week. As the General Registrar and his staff will soon be immersed in the laborious work of receiving, verifying, and counting ballot-papers, under the direction of the Branch Council for England, the comparative lightness of our agenda is highly convenient on this occasion,

A vote of thanks to the President for his address, with a request to let it be printed in the minutes, was

proposed by Dr. NORMAN MOORE, seconded by Dr. LITTLE, and carried by acc amation.

Moved by Dr. NORMAN MOORE, seconded by Mr. THOMSON, and agreed to after a short discussion, that the two following yearly tables, together with the Registrar's report thereon, be received and entered on the minutes :—

1. Table showing results of competition held in July, 1906, for commissions in the Army Medical Service.

2. Table showing results of competition held in July, 1906, for commissions in the Indian Medical Service.

In the report it appeared that there were forty-seven candidates, of whom twenty-five passed for vacancy, nine qualified, but were unsuccessful, and thirteen were rejected.

Moved by Dr. MCVAIL, seconded by Mr. YOUNG, and carried after a slight alteration—*i.e.*, the omission of the last five words—had been proposed as an amendment (which was lost) by Dr. SAUNDBY, seconded by Dr. ADYE CURRAN : " That the thanks of the Council be conveyed to the Director-General of the Army Medical Service and the Under-Secretary of State for India respectively for the returns which they had again furnished to the Council, with the request that these returns may in future continue to be furnished to the General Medical Council.

On the motion of Dr. NORMAN MOORE, seconded by Mr. THOMSON, the following report of the Executive Committee on the dental business transacted since the last meeting of the Council was received and entered on the minutes :—

REPORT.

(1) The prescribed conditions having been duly fulfilled in each case, the names of the undermentioned persons have been restored to the Dentists' Register, from which they had been erased in conformity with the provisions of Section 12 of the Dentists Act, 1878 :

Cameron, David J.	Hall, William H.
Campbell, George.	Harris, Harold O. W.
Dallachy, James W.	Highfield, Henry.
Davies, Bertrand S.	Hooper, Gordon.
Donovan, Frederick.	Mulliner, Thos. C. M.
Forewell, Henry.	Philson, Matthew S.
Gartrell, John H.	Washbourne, Henry A.

(2) Information was received, through the Colonial Office, of the intention not to proceed with a proposed Bill to regulate Dental Practice in the Colony of Hong Kong.

(3) The committee received from the authorities in England and Ireland promises to furnish to the Council records of all fines inflicted on dental practitioners, and an assurance from the Under Secretary for Scotland that the matter would receive attention.

(4) The committee received, through the Colonial Office, a copy of an Act to regulate the Practice of Dentistry in Newfoundland, and referred it to the Dental Education and Examination Committee for its information.

(5) A communication was received from the Royal College of Surgeons of England intimating that its Licence in Dental Surgery had been withdrawn from three dental practitioners whose names had been erased by the General Council at its May session.

DONALD MACALISTER,
November 26th, 1906. Chairman.

Moved by Dr. NORMAN MOORE, seconded by Sir JOHN WILLIAM MOORE, and agreed to, that the report from the Executive Committee as to the Revision of the Standing Orders relating to Visitation and Inspection be received and entered on the minutes

Moved by Dr PYE-SMITH, and seconded by Sir JOHN WILLIAM MOORE, that the report of the Executive Committee be adopted.

An amendment, moved by Dr. LINDSAY STEVEN, seconded by Sir JOHN BATTY TUKE, that in Clauses A2 and B2 the words, " and of the Education Committee acting jointly " be introduced after " Examination Committee," so that both clauses read : " It shall be the duty of the Examination Committee and of the Education Committee acting jointly to advise the Council . . . . . ," was carried, and the Standing Orders as amended were then adopted.

Moved by Dr. NORMAN MOORE, seconded by Mr. THOMSON, and agreed to : That the report as to other adjustments of the Standing Orders be received and entered on the minutes, and that power be given to the Executive Committee to issue the Standing Orders when read.

Moved by Dr. NORMAN MOORE, seconded by Mr. MORRIS, and agreed to : " That the report by the Executive Committee as to the result of the communication with the Privy Council to secure election of direct representatives by ballot be received and entered on the minutes. The report stated that the Privy Council had given its consent.

The Council having deliberated *in camera* on strangers being readmitted, the President announced that the Council had directed the Registrar to restore to the Dentists' Register the name and qualification of William Jones.

The Council then adjourned.

SECOND DAY, WEDNESDAY, NOVEMBER 28TH, 1906.

DR. MACALISTER, President, in the Chair.
Absent—MR. POWER.

The minutes of the last meeting having been read and confirmed, the Council proceeded to the consideration of the case of James William Ayres, registered as of 111, Farnworth Street, Liverpool, L.R.C.S.Edin., 1874, who had been summoned to appear before the Council to answer the following charges as formulated by the Council's solicitor : " That you were, on October 5th, 1905, convicted at the City Police Court, Liverpool, of being drunk in a certain public street in Liverpool, and guilty while drunk of riotous behaviour therein, and also that you were, on December 7th, 1905, convicted at the same Court of wilfully neglecting your children, who were all under the age of sixteen years, in a manner likely to cause them unnecessary suffering."

Mr. AYRES attended to answer his notice, but was not represented by counsel or solicitor. The solicitor of the Council, Mr. Winterbotham (in the absence of a complainant), read the two certificates of conviction set forth in the notice, and at the request of Mr. Ayres also read the letter which Mr. Ayres had sent in answer to his notice. Mr. Ayres then addressed the Council, and also answered questions put to him by the Council's solicitor. When strangers and Mr. Ayres had been re-admitted after the Council had deliberated *in camera*, the president announced the decision of the Council as follows :—Mr. Ayres, I have to inform you that the Council have deliberated very carefully on your case, and have passed the following resolution : "That James William Ayres having been proved to have been convicted of misdemeanour, the Registrar be directed to erase his name from the Medical Register."

The Council proceeded to the consideration of the case of Henry Cundell Juler, registered as of 141, Garfield Place, Cincinnati, Ohio, U.S.A., M.R.C.S., 1853, Lic. Midwif. R.C.S., 1854, M.D.Aber., 1855, L.S.A. Lond., 1856, who had been summoned to appear before the Council in answer to the following charge as formulated by the Council's solicitor :—" That information and evidence have been laid before the Council that you were, on July 10th, 1905, convicted at Marlborough Street Police Court of committing an act in violation of public decency in Hyde Park." Dr. Juler did not answer to his notice, nor was he represented by counsel or solicitor. The Council's solicitor, in the absence of any complaint, read the certificate of conviction, and put in two letters from Dr. Juler in answer to the charge, which were not read, as they were already in possession of the members of the Council. On strangers being re-admitted, after the Council had deliberated *in camera*, the President announced the decision of the Council as follows : " That Henry Cundell Juler having been proved to have

been convicted of a misdemeanour, the Registrar has been directed to erase his name from the Medical Register."

The Council then proceeded to the consideration of the case of Edmund McDonnell, registered as of 25, Hereford Street, Sheffield, L.R.C.P.Edin., 1880, L.R.C.S.Edin., 1886, who had been summoned to appear before the Council to answer the following charges, as formulated by the Council's solicitor:—

"(1) That you have acted as cover to an unqualified person, namely, Mr. William Williams Alnwick, and knowingly enabled him to attend and treat patients and otherwise to engage in medical practice as if the said William Williams Alnwick were a duly qualified and registered medical practitioner.

"(2) That you knowingly allowed the said William Williams Alnwick to fill up and sign in your name a certain certificate of death, namely, that of Ellen Millward, which stated that you had attended the said Ellen Millward in her last illness, and that you had last seen her alive on September 20th, 1906, whereas in fact you had not attended her or seen her, but the said William Williams Alnwick had alone attended and seen her.

"And that in relation thereto you have been guilty of infamous conduct in a professional respect.

"And further, that information and evidence have been laid before the Council that you were, on July 24th, 1906, convicted at the Sheffield City Petty Sessions on three charges of drunkenness, and that you were, on September 13th, 1906, convicted at Belfast of drunkenness."

Mr. McDonnell was called, but did not answer to his notice, nor was he represented by counsel or solicitor. Mr. Winterbotham read the notice, and also a supplementary notice, which he had sent relating to a later conviction for drunkenness. In the absence of any complainant, Mr. Winterbotham proceeded to lay before the Council the information on which the charge had been based. He read letters from the Registrar-General and the Deputy Coroner of Sheffield, together with the certificate of death of Ellen Millward. He also read a report of the evidence given by Mr. McDonnell at the inquest held on Ellen Millward, and the various certificates of Conviction, dated respectively June 5th, 1906, July 13th, 1906, July 24th, 1906 (two), and September 13th, 1906. Mr. Winterbotham read the letter which Mr. McDonnell had written in answer to his notice.

Strangers having been re-admitted after the Council had deliberated *in camera*, the President announced the decision of the Council as follows: "The Council have judged Edmund McDonnell to have been proved to have been convicted of various misdemeanours, and to have been guilty of infamous conduct in a professional respect, and have directed the Registrar to erase from the Medical Register the name of Edmund McDonnell."

The Council next received *in camera* an opinion of Dr. Blake Odgers and Mr. Lushington.

On strangers being re-admitted, Mr. YOUNG moved and Dr. MCVAIL seconded: "That it be remitted to the Students' Practical Midwifery Committee to consider and report as to the inclusion of clinical and practical work in the qualifying examinations in midwifery and gynæcology." This was carried after a short discussion, in which Dr. Finlay, Dr. Bruce, Sir Hugh Beevor, Dr. Norman Moore, Sir John Williams, and Sir Thomas Fraser took part.

Moved by Sir THOMAS MYLES and seconded by Dr. ADYE-CURRAN: "That it be remitted to the Education Committee to consider and report how far it may be possible to dispense with the compulsory attendances of students on the systematic courses of lectures in the theatres of medical schools, in order that the time so saved might be devoted to a more extensive study of the purely scientific portion of the curriculum or utilised in any such manner as may be found hereafter to be demanded by modern requirements." This motion met with considerable opposition from Sir Christopher Nixon, Sir John W. Moore, Dr. Norman Moore, Sir J. Fraser, Dr. Mackey, and Dr. Lindsay Steven. Sir Thomas Myles had made a strong but humorous reply, but the motion was lost—17 against, 7 for, 5 did not vote, 4 absent.

The next motion was proposed by Dr. ADYE-CURRAN and seconded by Dr. LINDSAY STEVEN: "That in consideration of the heavy expense entailed on the Apothecaries Hall, Dublin, by the appointment of the surgical examiners from London and Edinburgh respectively, the Council resolve that at the next vacancy surgical examiners be appointed from amongst the profession practising in Dublin." After a short discussion, Dr. Adye-Curran, with the consent of the Council and of his seconder, withdrew his motion.

The Council then adjourned.

THIRD DAY.—THURSDAY, NOVEMBER 29TH, 1906.

DR. MACALISTER, President, in the Chair.

THE Council considered a Report of the Dental Committee on the charge against Samuel Foley, William Henry Moseley, and James Parkinson. On November 6th, 1906, the two first-named attended in person before the Committee with counsel and solicitor, the last-named not appearing in person but being represented by his solicitor. The complainants, the British Dental Association, were represented by Mr. R. W. Turner.

The Committee found that the following facts were established by the evidence:—

(*a*) The three dentists above-mentioned are all on the "Dentists' Register" as in practice before July 22, 1878, and their addresses in the Register are as follows:

Samuel Foley, 266, Westminster Bridge Road, London, S.E.

William Henry Moseley, 6, St. Matthew's Street, Ipswich.

James Parkinson, 116, Uxbridge Road, Shepherd's Bush, London, W.

(*b*) On or about May 29th, 1899, the three dentists above-mentioned signed the Memorandum and Articles of Association, and thereby became members of a limited company named Foley's, Limited, incorporated under the Companies Acts for the purpose (*inter alia*) of carrying on the "business of dentists and dental surgeons."

(*c*) The company, immediately after its formation, entered into an agreement with an unregistered person named Edward Foley, a brother of the said Samuel Foley, for the acquisition from the former of five dental practices at the following addresses, namely, 75, Westbourne Grove, W.; 21, High Street, Kensington, W.; 95, North End, Croydon; 32, Tavern Street, Ipswich; and 89, King's Road, Brighton. The said unregistered person named Edward Foley was and is the sole and managing director, and also the principal shareholder of the company.

(*d*) The company now carries on practice at all the above-mentioned addresses except the last, and employs the said Edward Foley to attend patients and perform dental operations, and takes and uses the title of "dentists" and "surgeon dentists."

(*e*) The Company advertises systematically and extensively by circulars of an objectionable character and containing claims of superiority over other practitioners.

(*f*) Samuel Foley signed the Memorandum of Association of the company for five founders' shares, and William Henry Moseley and James Parkinson for ten Founders' shares each, but they have never paid anything in respect thereof or received any dividends thereon. The total issued capital of the company is sixty-five founders' shares and two thousand ordinary shares, all of £1 each, of which the said Edward Foley owns five Founders' shares and all the ordinary shares.

(*g*) Samuel Foley, at and previously to the formation of the company, practised at the same address as his brother, the said Edward Foley, namely, at 89, King's

Road, Brighton. He only resided there from Saturday till Monday in each week. He subsequently handed over the premises and the brass plate bearing the inscription, "Mr. Foley, Dentist," and the furniture and appliances to his brother, and ceased to practise there himself.

The said Samuel Foley took no part in the management of the business carried on by the company, and was carrying on a practice himself elsewhere, but he was well aware of the object with which the company was formed, and knew that it was to enable his brother as an unqualified person to advertise himself and carry on practice as a dentist and surgeon dentist.

(*h*) The said William Henry Moseley, at and previously to the formation of the company, and for about three years subsequently thereto, was in the employ of the said Edward Foley, and he signed the Memorandum of Association at the request of the said Edward Foley.

All three now appeared to answer their notices. Mr. S. Foley was accompanied by his counsel, Mr. Courthope-Munroe, Mr. W. H. Moseley by his solicitors, Mr. J. H. Ryley, of Ipswich, and Mr. Priest; and Mr. Parkinson by Mr. R. C. Kerr. The British Dental Association was represented by Mr. R. W. Turner, counsel. Mr. Courthope-Munroe, Mr. Priest, and Mr. Kerr addressed the Council on behalf of their respective clients, and Mr. Turner replied on behalf of the complainants. After the Council had deliberated *in camera*, the parties and strangers were re-admitted, and the President addressed Mr. Foley as follows: "Mr. Foley, I have to announce that on the facts found in the Report of the Dental Committee, in your case, it has been proved that you have been guilty of conduct which is infamous or disgraceful in a professional respect, and the Council directs the Registrar to erase your name from the 'Dentists' Register.'"

The President then addressed Mr. W. H. Moseley and Mr. J. Parkinson as follows: "I have to announce to you that the further consideration of the charge against you has been postponed until the next Session of the Council, when you will be expected to show to the satisfaction of the Council that you have done your best to sever all connection with the company of Foley's, Limited, and that your professional conduct has been in all respects satisfactory in the interval."

The Council next proceeded to the consideration of the report of the Dental Committee on the charge against William Williams Alnwick. On November 28th, 1906, Mr. W. W. Alnwick attended before the Committee and was heard.

The case having been brought to the attention of the Council by the Registrar-General, the facts were laid before the Committee by the solicitor.

The Committee find that the following facts were established by the evidence:—

(*a*) The said William Williams Alnwick is on the "Dentists' Register" as in practice before July 22nd, 1878, and of the address 39, Highfield Place, Sheffield.

(*b*) The said William Williams Alnwick, being a registered dentist, but not being a registered medical practitioner, has attended and prescribed for patients as though he was a duly qualified and registered medical practitioner, and has, in the name of one Edmund McDonnell, a duly registered medical practitioner, signed a death certificate in the case of Ellen Millward, whom the said William Williams Alnwick had so attended and prescribed for.

(*c*) The said William Williams Alnwick has been carrying on a general medical practice for over thirty years.

(*d*) The said Edmund McDonnell has resided for the last eight or nine years with the said William Williams Alnwick, and has been his "assistant partner" in medical practice.

The said William Williams Alnwick was authorised by the said Edmund McDonnell to sign his name to the certificate of death of the said Ellen Millward, although in fact the said William Williams Alnwick alone had attended her, and the said Edmund McDonnell had not attended her.

(*e*) The said William Williams Alnwick was convicted on October 30th, 1906, at the Sheffield City Police Court, of forging the certificate of the death of the said Ellen Millward for the purposes of the Births and Deaths Registration Act, 1874, and was fined £3 14s. and £1 6s. costs.

Mr. Alnwick attended in answer to his notice, and, after the Report had been read, he addressed the Council. Among other things he said he had attended over 2,000 cases of midwifery. After the Council had deliberated *in camera*, when Mr. Alnwick and strangers had been re-admitted, the President announced the decision of the Council as follows: "That William Williams Alnwick having been proved to have been convicted of a misdemeanour, the Registrar, has been directed to erase his name from the 'Dentists' Register.'"

The Council again went into *camera* to receive a Report by the Dental Committee in regard to certain applications for the restoration of names after erasure under Section XIII. of the Dentists Act.

Strangers having been re-admitted, it was moved by Dr. McKay, seconded by Dr. Norman Moore, and agreed to: "That the Report from the Education Committee on the operation of recommendation of the Council in regard to the fifth year of professional study be received and entered on the Minutes."

Moved by Dr. Mackay, seconded by Dr. Norman Moore, and agreed to: "That the following alteration, as recommended in the Report, be made in the Recommendations of the Council: 'That the reference to a period of pupilage' be adopted." Another Recommendation in the Report: "That special reference should be made to instruction of anæsthetics," was adopted, on the motion of Dr. Mackay, seconded by Mr. Morris.

The adoption of a third Recommendation in the Report: "That special reference should be made to attendance at *post-mortem* examinations," was proposed by Dr. Mackay and seconded by Dr. Lindsay, Steven. An amendment, however, was moved by Mr. Young, seconded by Dr. McVail, that the following words be substituted: "To giving attendance at and taking part in, *post-mortem* examinations." After a lengthy discussion, in which Dr. Lindsay Steven, Sir John Moore, Dr. Caton, Mr. Morris, Sir C. Nixon, Dr. Norman Moore, Dr. McVail, Dr. Little, Dr. Saundby and Mr. Brown took part, the closure was carried and the amendment put and lost—20 against, 8 for, 2 did not vote, 3 absent. The original motion was then put and carried.

Moved by Dr. Mackay, seconded by Dr. Lindsay Steven, and carried: "That the Recommendation in the Report, 'That statistics relating to the length of the curriculum actually pursued by students under the present regulations should be procured and laid before the Council,' be adopted."

Sir John Tuke was appointed a Member of the Finance Committee and on the Dental Committee on behalf of the Scottish branch, and Dr. Little on behalf of the Irish branch on the first Committee.

An amendment moved by Dr. Norman Moore, seconded by Dr. Lindsay Steven: "That from the Reports of the Examination Committee the passages referring to the Order of Merit be omitted," to Dr. McVail's motion, seconded by Mr. Young: "That the Reports of the Examination now presented in regard to the result of examinations for the Public Services" be received and entered in the Minutes, was carried, and it was agreed that the Reports thus amended should be received and entered in the Minutes.

The President announced the appointment of Sir T. R. Fraser as a member of the Examination Committee on the nomination of the Scottish Branch Council in the place of Sir P. Heron Watson.

The Council then adjourned.

Fourth Day, Friday, November 30th, 1906.

Dr. MacAlister, President, in the Chair.

Moved by Sir John Tuke, and seconded by Dr. Mackay: That the note to Requirement III. in regard

to Professional Education be deleted and that in its place the following note should be adopted: "That the Council is of opinion that the required subjects should be divided into two groups; one group comprehending Physics, Chemistry, Elementary Biology, Anatomy, and Physiology, the other comprehending all the other subjects; and that the Council is of opinion that no licensing body should recognise instruction in any subject comprehended in the second group until candidates have passed in the subjects comprehended in the first group." Sir T. McCALL ANDERSON, seconded by Sir JOHN MOORE, moved an amendment to the effect that a minimum of two years be devoted to the final examinations, and no qualifying courses be recognised till all the preliminary courses be passed.

A long discussion followed, in which Sir Thomas Fraser, Dr. Caton, Sir C. Nixon, Mr. Morris (who pointed out that the question of treating preliminary scientific subjects apart had been before the Council since 1864), Dr. Norman Moore, Sir John Williams (who, seconded by Dr. Little, moved as rider that the education of the student should be divided into three groups), Dr. Bruce, Dr. Lindsay Steven, Sir Thomas Myles, Dr. Kidd, Mr. Thomson, and Dr. McVail took part. Another rider was proposed by Dr. Kidd, seconded by Dr. Saundby, and eventually the original motion, the amendment and the two riders were referred by vote to the Educational Committee.

Moved by Sir JOHN MOORE, seconded by Sir THOMAS MYLES: That the Governor and Court of the Apothecaries' Hall, Dublin, be requested to furnish for the information of the Council a statement showing in reference to the Final or Qualifying Examination of that body: (1) The number of candidates who have presented themselves for the said examination since the appointment of Examiners in Surgery by the Council; (2) the number of candidates who have been successful at the said examination; (3) the subjects in which the unsuccessful candidates have failed; (4) the numbers rejected in each of the subjects in question.

Mr. BROWN moved as an amendment; seconded by Dr. ADYE-CURRAN: "That the Registrar be requested to afford the information." The motion, as amended, was voted as follows: 12 for, 9 against, 7 did not vote, 5 absent. Mr. THOMSON challenged the motion being carried on this voting as "not being the voting of the majority of the members present."

Moved by Dr. ADYE-CURRAN, and seconded by Dr. SAUNDBY: "That the existing appointments of Assistant Examiners in Surgery at the Apothecaries Hall, Dublin, be terminated next May." This was carried, after some words of praise to the out-going examiners had been added at the suggestion of the President.

Moved by Sir JOHN WILLIAMS, seconded and agreed to: "That the Report from the Students' Practical Midwifery Committee be received and entered on the Minutes."

The PRESIDENT next made a statement on behalf of the Executive Committee in regard to the extension of Part II. of the Medical Act, 1886, to Nova Scotia and to Japan.

Moved by Mr. TOMES, seconded by Mr. MORRIS, and agreed to: "That the Report of the Dental Education and Examination Committee be received and entered on the Minutes." The Recommendation that the Council accede to the request of the University of New Zealand for the recognition of the degree of Bachelor in Dental Surgery was adopted. The same application from the University of Sydney was postponed for further information on the points indicated. The Committee had recommended that the preliminary examination in general knowledge of the College of Dental Surgeons of Quebec be not recognised.

The Report of the Pharmacopœia Committee was received, entered on the minutes, and approved.

Moved by Mr. BROWN and seconded by Mr. JACKSON: "That representations be made to the Privy Council that it is expedient to confer on the Registered Practitioners resident in England and Wales the power of returning an additional member to the General Council." This motion was lost: 12 against, 10 for, 2 did not vote, 9 absent.

Moved by Sir HUGH BEEVOR, seconded by Dr. NORMAN MOORE, and agreed to: "That the Report of the Student's Registration Committee be received and entered on the minutes.

Dr. BRUCE then moved, and Mr. BROWN seconded, a vote of thanks to the Chairman. This motion was carried by acclamation.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris Dec 2nd 1906.

HÆMOPHILIA.

UNDER the name of hæmophilia is recognised a special disposition to hæmorrhages. This disposition is sometimes acquired, but in the immense majority of cases it forms an essential hereditary malady. It can be transmitted from father to son, from grandfather to grandson, passing over a generation. Hæmophilia is rare in girls, boys being almost exclusively affected. In half the cases the affection is not hereditary, but is always congenital.

The geographical distribution of hæmophilia is interesting from the fact that it seems to have a predilection for the northern countries, and especially Germany, England and America. According to Dommartin, who made a study of 100 cases, Germany furnished forty-eight, England eighteen, Switzerland nine, and France eight. The malady is endemic in certain places; it is thus that Vieli found fifteen or twenty hæmophilic families in Rhœzveus, an Alpine village, which he attributed to consanguinity. The Jewish race appears to be particularly predisposed to the malady. The first symptoms of hæmophilia generally show themselves in the first two years of life; after the age of twenty-two all risk disappears.

Hæmophilia is characterised, clinically speaking, by a particular condition of the blood and by three orders of symptoms: external, spontaneous, or traumatic hæmorrhage; insterstitial hæmorrhage (ecchymosis, hæmatoma), and hæmorrhage of the articulations.

Spontaneous hæmorrhage appears as the result of a fit of anger or emotion, or from no apparent cause. It is frequent in spring and autumn, and occurs at night rather than in the daytime. It is generally observed in the form of epistaxis, which is frequently so abundant as to threaten the life of the patient. The gums and mucous membrane of the mouth are also frequently the seat of hæmorrhage, while such accidents as intestinal hæmorrhage, hæmoptysis, menorrhagia, and, above all, hæmaturia, have been observed.

Traumatic hæmorrhage results from the slightest wound or scratch, and is often very grave. According to Grandidier, out of forty-five cases which ended fatally, the hæmorrhage was produced in eleven cases from a slight scratch of the scalp, fourteen from a small break in the skin, or in the mucous membrane of the lips, seven from a bite of the tongue, five from epistaxis provoked by a fall, and in the other cases death by hæmorrhage was caused by an insignificant wound of the foot, the finger, &c. All these cases were purely accidental, but frequently also the hæmorrhage was provoked by a surgical operation. Out of forty cases Grandidier includes avulsion of teeth ten, bleeding six, wet-cupping four, leeches four, circumcision four, section of the umbilical cord eight.

Interstitial hæmorrhage can be observed in the layers of the skin in the form of ecchymosis and petechia, or the blood may follow the sheaths of the muscles,

constituting hæmatoma. When it is spontaneous, the ecchymosis is most frequently on the lower limbs, the tongue and the palate. Traumatic ecchymosis covers a large surface, invading frequently a whole limb. The slightest cause, a pinch, an insignificant knock, is sufficient to provoke it. A patient of Dommartin had an extensive ecchymosis on the gluteal region from sitting on a hard seat.

Hæmatomata occupy particularly the cellular subcutaneous tissue, and the muscular sheaths, especially that of the psoas. It may be spontaneous, or the result of a more or less violent effort. It is accompanied frequently with pain, when it compresses a nerve trunk, sciatic or brachial nerves. The skin covering it is shiny, brilliant and hot, while the temperature sometimes runs high, but in general fever is absent. Hæmatoma rarely suppurates; it is absorbed without leaving any trace.

Hæmophilia or hæmorrhage into the articulations has been particularly studied by Dubois and König. It can be produced by traumatism, but is generally spontaneous. It is observed principally at the large joints (knees, elbows, ankles, hips, shoulders). König recognises three periods in this accident: the first consists of effusion of blood into the articulation, accompanied with fever (repeating hæmarthrosis).

In the second period, the synovial membrane and the cartilages become affected; the joint is swollen, but there is no local temperature, nor has suppuration ever been observed. The neighbouring muscles become atrophied, as in the case of infectious arthritis.

If the blood is not absorbed, the third period sets in, which is that of ankylosis. A frequent error is in the confusion of this curious affection with white swelling, and can only be avoided by closely interrogating the patient on his previous history.

The prognosis of hæmophilia is always very sombre. According to Litten, 60 per cent, of the patients die before eight years of age, while only 12 per cent. live over twenty-two years of age.

The treatment of hæmophilia is limited and unsatisfactory. Reverdin recommended sulphate of soda in small doses (2 grains every two hours), and acidulated drinks. A prolonged use of chloride of calcium or of the dried extract of pig's liver is about the best preventive treatment.

In the treatment of the hæmorrhage itself absolute rest should be imposed on the patient, and chloride of calcium (1 drachm daily) be ordered. Where it is external (epistaxis or cutaneous hæmorrhage following a wound), compression should be applied, and in obstinate cases a local application of a solution of adrenalin (1 in 10,000) is very successful.

Where the patient has fallen into profound anæmia, an injection of artificial serum might be tried. But here, again, the small wound might give rise to another hæmorrhage, consequently, the injection should not be made unless the life of the patient is in danger.

The treatment of arthritic hæmophilia consists in compression and the fixing of the joint in a good position.

GERMANY.

Berlin, Dec. 2nd, 1906

At the Society for Innere Medizin, Hr. Katzenstein made observations on

• The Influence of Gastroenterostomy on Ulcer and Carcinoma of the Stomach.

After observing that very little had been done in this direction beyond the examination of test breakfasts, which often gave negative results, he proceeded to state that his investigation had included examination of animals both before and after gastroenterostomy, and after various articles of food. He had ascertained (1) that after gastroenterostomy of any kind both pancreatic juice and bile passed freely into the stomach. (2) This inflow of alkaline fluid into the stomach was continuous in the early period after the gastroenterostomy—probably through a reflex process founded on the steady secretion of these fluids—but later on the inflow was periodical only. (3) Some months after the operation, after feeding with flesh alone, the pancreatic ferments and bile were demonstrable in the stomach about 1½ hours after taking food; when fat was given, or water, they were found there in half an hour. From this the speaker concluded that both fats and water have the property of exciting when in the stomach the secretion of these fluids by a reflex route, as the reflex could not be excited from the duodenum, that having been shut off from the stomach artificially. This was confirmed in the case of a patient who had had gastroenterostomy performed for carcinoma of the pylorus, and who was given a trial breakfast of fat. (4) The consequences of the inflow of alkaline intestinal juices into the stomach were: diminution of acidity and of pepsine digestion, as pepsine was rendered inactive by even a transitory neutral or alkaline reaction. This lowering of the acidity was caused not only by the actual neutralisation of the acid by the alkali, but also by a reflex lessening of acid secretion. There was also slight weakening of the action of the pancreatic ferments. The ferments, as was shown by the speaker's experiments, were not rendered inactive by a transient acid reaction, as had been assumed. The action of the trypsine began again when the reaction again became neutral; the weakening being dependent on the duration of the acid reaction; but after even twenty-four hours the trypsine action was demonstrable as soon as an alkaline reaction was re-established. This resisting power of the pancreatic ferments was an indispensable condition of efficient nutrition after gastroenterostomy.

He was of opinion that one of the factors for the origination of a gastric ulcer was hydrochloric acid, and that it was the chief factor for its persistence. With gastroenterostomy, therefore, according to his views, a mode of causal treatment was put into action as the production of hydrochloric acid was diminished by it.

The arrest of growth of carcinoma of the pylorus, often observed after the operation of gastroenterostomy, was due, in the speaker's opinion, to a superficial digestion of the tumour by trypsine. For this reason he would extend the indication for gastroenterostomy to every no longer resectionable carcinoma. As regarded ulcer, the indication should stand as before, and gastroenterostomy should be performed only after the failure of all other forms of treatment.

Hr. Ewald had never seen any action of the pancreatic juice on carcinoma. The result of gastroenterostomy on dogs would not necessarily be similar to those on the human subject, as the posture in the dog facilitated the passing of intestinal juices into the stomach, whilst the erect posture of the human subject would make it difficult. In the human subject the inflow in question depended on inefficient function. The results of gastroenterostomy were not always brilliant even in ulcer, as the symptoms sometimes returned after even repeated operations. Amongst the public there were two groups of people, the one would not be operated on at all, and the other not half early enough. The dangers of the operation were much under-estimated. He had seen not a few deaths in carcinoma of the stomach after gastroenterostomy, and as a direct consequence of the operation and especially from collapse.

Hr. Rosenheim had only operated in ulcer of the stomach when there was motor insufficiency and bleeding that threatened life that could not be arrested. The operation results after other indications were not encouraging. He had not seen any diminution in acidity after gastroenterostomy, although he had carefully looked for it for years. He would not extend the indication for operation in gastric ulcer. In regard to carcinoma, he was still more sceptical; he had never seen life prolonged by operation for carcinoma of the pylorus. What happened to those operated on? (1) The symptoms might return; (2) unfavourable conditions as regarded nutrition arose, often stasis in the small intestine; (3) not infrequently ulcer of the jejunum came on, with results that threatened life. (Discussion adjourned.)

At the Medical Society, Hr. L. Lewin brought for-

ward a new remedy for cardiac diseases in the shape of a preparation from the

ACOCANTHERA SCHIMPERI.

For many years he has been studying arrow poison as employed by African natives, which had, as has long been known, an enormous influence on the heart. He had at last succeeded in preparing a glucoside which chemically and toxicologically resembled chrystalline ouabine, except that it was amorphous. He had therefore given it the name of amorphous ouabine. It was found in the wood of the Acocanthera Schimperi, which was widely distributed over the whole of East Africa, and is the most important source of arrow poisons. Ouabine slowed the pulse, strengthened the systole, and with this raised the blood pressure.

AUSTRIA.

Vienna, Dec. 2nd, 1906.

MAXILLARY DEFORMITY.

LORENCZ showed a young girl, æt. 10, who suffered from congenital malformation in the upper maxillary. Cleft palate, hare lip, with a fissure up the centre, were ingeniously closed, leaving the face perfect without a scar.

XANTHOMA TUBEROSUM.

Spiegler showed a case of xanthoma tuberosum in a man, æt. 39, where there were neither glycosuria or hepatic disease, which are considered by some necessary diagnostic signs.

RÖNTGEN PHOTOS OF THE CRANIUM.

Benedikt showed a few photos of cranium and morbid changes in cerebrum from three cases in hospital, all caused by falls. Strange to say all the cases had the lesion in the frontal lobes, although the manner of the fall differed in all the three cases. All of them lost the power of standing erect, and in the effort would fall to one side or the other on the floor. This centre of disturbance is not yet explained, and seems to be erratic in its development. We cannot even determine whether the lesion is cortical or subcortical, as it lies in front of the so-called psychomotor zone.

In the first case, the rays showed the frontal sinuses in one side enormously increased in bony growth closing the connection. Later this bony increase invaded the opposite sinus, becoming dense and opaque. This eburnation extended to both sides of the cranium, and could have no connection with pregnancy or syphilis. The use of iodide and mercury reduced the attacks, and the patient slightly improved.

As a rule the outer lamella of the cranium is as transparent as the inner, but in injuries to the head the outer lamella becomes more opaque than the inner, which seems to be of pathological importance in the diagnosis. Another point to be noted is the peculiar bands to be found in the substantia spongiosa. To illustrate this he showed a plate taken from a man who had his head injured when he was twelve years of age in the parietal region. In this photo distinct bands are seen in the spongiosa of the frontal and parietal bones. A second photo where the disturbance had been in the frontal bones showed distinct spongiosa bands with osseous thickening and a dark centre in front of the psycho motor region, which was probably the centre of disturbance. A third plate showed a depression on the frontal side of the frontenelle, which also clearly showed the bands in the spongiosa of frontal bone.

A few plates from the occipital region showed neoplasms in the cerebellum, which were afterwards dissected in the *post-mortem* room, and found to be soft tumours.

In conclusion, he said that the technical failures in the plates taken by the rays lay in the differentiation of exudations, abscesses and neoplasms of the brain substance.

In the discussion that followed, Schuller remarked that Benedikt's diagnosis should be carefully borne in mind, but according to his own experience the Röntgen rays were only useful in a very limited group of cases, such as injury to the cranium, foreign bodies, or projectiles. They might also be employed for examining fissures, impressions, and depressions of the cranium, also in destructive processes such as hyper-ostosis, local and diffuse. Grossmann thought them useful in the diagnosis of rhinology.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

MEDICAL MAN AS CONVENER OF THE EDINBURGH PUBLIC HEALTH COMMITTEE.—Dr. Matheson Cullen, who has for a number of years done excellent work on the Town Council, and as a member of this Committee, has now deservedly been elected its convener, in place of Mr. Gilson, who has been made Lord Provost.

SEAFORTH SANATORIUM FOR CONSUMPTION.—This sanatorium, which will accommodate twelve patients, and is the first institution of its kind in the United Kingdom to be erected, equipped, and endowed for the free treatment of patients by private munificence, had its foundation stone laid on November 27th by Mrs. Stewart Mackenzie, of Seaforth, to the generosity of whose husband the County of Ross-shire owes the new undertaking. The buildings, which will consist of two blocks, are being erected on the Seaforth estate, about two miles from Dingwall. Each patient will have a separate room, and on the south side of the building large sliding glazed screens open on to a broad terrace 200 feet long, on to which the beds and couches can be pushed when desired. The site has been selected with special care; it slopes to the south, and is sheltered on the north by pine woods. During the ceremony Colonel Stewart Mackenzie emphasised the two-fold object of the sanatorium—first, to cure cases of early phthisis, and second, to educate the people in the value of fresh air as a preventive measure.

PREVENTION OF CONSUMPTION IN GLASGOW.—The annual report of the local branch of the National Association for the Prevention of Consumption states that since their last report the important step has been taken of opening a dispensary where special advice and treatment may be received. The dispensary is under the care of Dr. James Scott, and is already proving a valuable agency both in selecting suitable cases for the Bellefield Sanatorium, and in treating severe and acute cases. The report goes on to draw attention to the fact that so many patients, when they fail to be admitted to the sanatorium, cease attending the dispensary. It would, therefore, be a great advantage to the community if a home or hospital could be provided in the city for advanced cases, so that these should not be compelled to live on in crowded, airless houses. During the year 95 patients have been admitted to Bellefield sanatorium, of whom 40 are reported as having had the disease arrested, 36 as improved, 12 not improved, and two dead. Plans have been prepared for the erection of another pavilion accommodating 22 patients. The report was adopted at the annual meeting held on the 27th inst., when the Lord Provost, who presided, spoke particularly of the steps which were being taken to provide suitable employment for patients after they had left the sanatorium.

BELFAST

THE IRISH UNIVERSITY QUESTION.—The problem of the Irish University Education is being widely discussed at present in medical and professional circles generally in the North of Ireland. This is partly owing to the way in which it was brought forward by Professor Schafer, of Edinburgh, in his speech at the annual dinner of the Ulster Medical Society, as reported in this column a fortnight ago, and partly to the fresh impetus towards a solution given by Mr. O'Brien's generous offer to Cork. A few years ago the number of medical men in Belfast who openly advocated an Ulster University could have been counted on the fingers of one hand—and probably a few fingers could have been spared—but a considerable change

has developed of late, and is still making progress. The two stock arguments against an Ulster University have been that it would be a Presbyterian University, under clerical domination, and that its degrees would be unknown and consequently worthless. But, however much the General Assembly of the Presbyterian Church may wish to control higher education in Ulster, and it is only fair to say that there is no evidence of such a wish on the part of that body, the ordinary Ulster layman is about as little likely to submit to such domination as any man in the world. And as regards the second objection? Belfast is a commercial city, and men know enough of commerce to realise that though an old-established trade-mark may be an excellent asset in a business, a young firm who show enterprise and turn out a good article will soon command a market. Taking too low an estimate of his own abilities is not generally the most prominent failing of an Ulsterman, and there is no doubt that the changes at Queen's College brought about by the Better Equipment Fund have convinced many men that there is a great future in store for the Northern school. That such future will be best attained by an independent school working out its own fate in conformity with local needs and the genius of the province is the opinion of an increasing number of northern graduates.

LETTERS TO THE EDITOR.

THE ELECTION OF THE GENERAL MEDICAL COUNCIL.

To the Editor of The Medical Press and Circular

Sir,—In my note on the election of the General Council (Medical Press and Circular, November 14th) I was careful not to advocate any particular candidate, but having been asked to do so I could not, of course, do more than compare the candidates' addresses with the principles I laid down.

In the first place, Dr. Langley Browne goes out. He advocates taxation—that the profession should pay the Government £37,000 per annum. The omission of this name carries with it the other so-called Association candidates—McManus and Latimer.

Next, there is a general feeling that a clean sweep of all the former members should be made, but this is certainly not universally held, and it is possible that one or both will be returned.

For the Midlands and the North of England, there is no one of the position and authority of Dr. Broadbent, who is, morever, one of those conversant with provident dispensaries.

One principle I did not lay down, namely, the desirability of sending young men to the Council. The conditions of social life are so rapidly changing that the alert mind as well as the wise restraint is needed. The Benjamin of the candidates, qualified in 1885, Dr. Fred J. Smith, is certainly worthy of the honour. Being a university man, he would probably be able to influence the professors, and of Oxford, he would look after the Philistine president, who is of Cambridge.

Dr. Joseph Smith will be supported by a good many "college" men. Of course, my outlook is but that of a London resident. There are currents in the country of which we have little knowledge, and if in the division of votes either or both the other country practitioners are elected, I myself will applaud.

I am, Sir, yours truly,
G. Crichton.

114, Lexham Gardens, Kensington, W.,
November 30th, 1906.

To the Editor of The Medical Press and Circular.

Sir,—It may be thought by some that it is too late publishing any further letters on this election, as Friday next is the last day for voting papers to be received; but I venture to point out that there are perhaps half the number of papers which have not been sent in, therefore, if the readers of the Medical Press and Circular will bestir themselves, and send their copies of it to friends, many votes may be obtained, and although my sympathies are with Dr. Broadbent as the most suitable candidate for furthering and protecting the interests of general practitioners, what I desire above all things is that we should endeavour to rouse interest in the election, and to obtain a large poll.

I am, Sir, yours truly,
H. T. Wylde.

Manchester, December 1st, 1906.

To the Editor of the Medical Press and Circular.

Sir,—The letter of "An Elector" under the above heading in the Medical Press and Circular of the 28th ult. has touched upon a subject of great moment to many general practitioners in London, especially those in proximity with Provident Dispensaries.

How can men be expected to make a decent livelihood when members are received into these dispensaries who pay rentals of £35 a year, with, of course, rates in proportion?

I will only ask the courtesy of space in your next issue to say that I am glad to see that there is at least one candidate in this election who is determined to make a stand on the question of "Contract Practice" in general, and Provident Dispensaries in particular, to the latter of which he has given special attention in opposing them for many years. I allude to Dr. G. H. Broadbent, of Manchester, who is a tried man, and whom, I believe, we can trust as a thoroughly sound and sympathetic representative. I, therefore, hope those who have not yet sent in their voting papers will do so at once, and vote only for him, and so practically give him three votes.

I am, Sir, yours truly,
M. S. Hadford.

192, Wandsworth Road, London, S.W.,
December 1st, 1906.

OBITUARY.

GEORGE BAGOT FERGUSON, M.A., M.D., F.R.C.S.

We regret to announce the tragic death of Dr. G. B. Ferguson, of Cheltenham. In the evening of November 28th, Dr. Ferguson was operating on a patient at the Cheltenham Hospital when he was taken suddenly ill and died almost instantly. Dr. Ferguson was one of the best known and most highly respected general practitioners in the provinces. As an Oxford man in his young days he greatly distinguished himself, taking a First Class in his final Honours Schools before entering at St. Bartholomew's. After serving as house-surgeon to that institution, he went to practise at Cheltenham, and owing to his high attainments and remarkable energy he soon achieved marked success. In 1875, he graduated M.D. of Oxford, having taken his M.B. four years previously, but his partiality for surgery showed itself as years went on, and as late as 1902 he took the F.R.C.S. of England, and in 1903 the degree of Master of Surgery at Oxford. He was always interested in the prevention of disease, and made several useful contributions to the literature of their subject, especially "The Bacteria and their Allies" in 1884, and "History, Nature, and Prevention of Cholera" in 1885. He also wrote a number of papers, principally on surgical subjects, in St. Bartholomew's Hospital Reports. When the British Medical Association visited Cheltenham in 1901, he was elected President, and those who were present at the meeting well remember the charming address he gave on "Scientific Research," and the "go" he put into the work of his office. Lately, for some little time, he had had trouble with his heart, but he never gave up work. It is pathetic, in the light of recent circumstances, to recall the last words of his Presidential address,

"There is no death! What seems so is transition.
This life of mortal breath
Is but a suburb of the life Elysian
Whose portals we call Death."

MEDICAL NEWS IN BRIEF.

Irish Medical Schools and Graduates' Association Dinner.

A HIGHLY successful dinner and entertainment was given at the Hotel Great Central by the Irish Medical Schools and Graduates' Association on November 20th. This Association is alone among the social medical organisations in the Metropolis in admitting ladies to its entertainments, and so much do the members appreciate the privilege that last Wednesday night quite half of those present were of the more desirable sex. Indeed, if the Irish Graduates' dinner were remarkable for nothing else, it was certainly noteworthy in that it attracted a bevy of ladies who for beauty and vivacity could safely hold their own in any assembly in London. To meet them and the members of the Association came many distinguished guests, Admiral of the Fleet Sir Edward Seymour, G.C.B., O.M., the guest of the evening, Sir Dyce Duckworth, Sir Kendal Franks, Dr. Pye-Smith, Mr. Mayo Robson, Dr. McVail, and other well-known people. The Chairman of the Council, Dr. Irwin Scott, presided, and he was supported by Director-General Sir Alfred Keogh, Inspector-General Lloyd, Sir Lambert Ormsby, Sir John Moore, Surgeon-Lieutenant-Colonel Moorhead, Dr. James Stewart, Mr. Charles Ryall, Dr. Macnaughton Jones, and Mr. Canny Ryall (secretary). To the last-named the greatest credit is due for the excellence of the organisation of the dinner, which, together with the entertainment that followed it, bore striking testimony to the skill and foresight with which the arrangements had been made. Besides the cheering influence diffused by the presence of ladies, the dinner gained by the absence of the depressing influence of long-winded and unnecessary speeches. Beyond the customary loyal toasts, "Our Guests," succinctly proposed by Sir Alfred Keogh, and appositely replied to by Sir Edward Seymour and Dr. James Stewart, provided the only occasion for speech-making. After business came pleasure, and the members of the Association and their guests were subsequently entertained by an excellent series of "turns" given by artists of various talents. A show of "Live Marionettes," in which the performer arranged that his own head should surmount the marionette's body, provoked great merriment; it was a clever idea cleverly carried out, and proved quite a feature of the evening. But the whole went with a "click" from start to finish, and it is difficult to say which were the better pleased —the hosts with their guests' enjoyment, or the guests with their hosts' hospitality.

Premium on Baby Rearing.

FOLLOWING the successful example set by the ex-Mayor of Huddersfield, it is announced that the Mayor of Marylebone, London (Sir Thomas Brooke-Hitching) will, with a view to diminishing a high infantile mortality rate in the poorer parts of the borough, present the mother of each child born in Marylebone with £1 on its becoming a year old. The gift will be limited to poor parents in the receipt of less than £2 per week. It is hoped that this may prove an incentive to increased care and attention in the rearing of infants. At the same time, efforts are to be made of an advisory character in the best methods of nurture and treatment in necessary cases. The mayoress will take an active part in the good work.

Metropolitan Hospital Sunday Fund.

THE LORD MAYOR presided at a meeting last week in connection with the Sunday Hospital Fund at the Mansion House, at which the Hon. Sidney Holland, one of the executors of the late George Herring, stated that the fund would benefit to the extent of £600,000 from the estate. He added that £60,000 had been bequeathed to the "Back to the Land" scheme of the Salvation Army, in addition to £40,000 already given; but if that scheme did not prove successful the £60,000 would come into their fund. A vote of condolence was passed with the relatives of the deceased gentleman, and it was decided to place the marble bust of the late Mr. Herring, which was now at the deceased gentleman's house, in the Mansion House. Archdeacon Sinclair presented the financial statement, which showed that £63,000 was collected this year.

The Local Government Board and Alcohol.

THE auditor having criticised the large expenditure on alcohol in one of the districts of the Epping Union, Essex, caused by a medical officer regularly ordering wine or spirits as a medical comfort to aged people in receipt of out-relief, the Epping Guardians asked the Local Government Board to define their powers in the matter. At a guardians' meeting recently a letter was read from the Local Government Board stating that the medical officer's order was legally only an expression of opinion, and, therefore, the guardians could, if they chose, refuse to supply alcohol. It was decided that alcohol be only supplied in urgent cases in future, and that the medical officer ordering it must give a medical reason for so doing.

Hospital Accommodation for Consumptive Patients.

A CONFERENCE of Middlesex councils was held at the Guildhall, Westminster, last week, to consider a proposal made at the general meeting of the Middlesex District Councils' Association, that the local authorities in the county should combine for the purpose of providing hospital accommodation for persons suffering from consumption. Mr. A. W. W. King (Acton), the chairman of the association, who presided, said that he was sure that anything they could do as public health authorities, within their means, they would be happy to do, and what they wanted to find out was the best way to tackle the problem. They had the power of spending the ratepayers' money to try to counteract the effects of the disease, but at the same time had to consider questions of finance, and that made it difficult to take the necessary steps unless the cost was kept down as much as possible. Colonel Gerard Clark, the hon. secretary of the proposed Middlesex Open Air Sanatorium, gave an address. What they wanted, he said, was the simplest possible buildings, with the patients' accommodation so permeated with fresh air that the bacillus could not live in it, and, above all things, it was of vital importance that the establishment should partake of the nature of a labour colony, and that the weekly cost should be as moderate as possible, in order that the poor might be able to have the freest possible recourse to it. He said it was estimated that the capital cost of furnishing the house and providing everything to deal with 50 patients at a time, would be £2,500, which sum might possibly be provided by private persons. The rent of the house would be about £160 a year, and the full maintenance charges would not be more than 25s. a bed per week, a total cost annually of about £3,500. He felt it was so necessary to make a beginning that, although the taking of a house with about two-and-a-half acres of ground was by no means an ideal scheme, it would start the movement, which could, later on, be further developed. The 50 beds would only deal with about 100 patients a year, but at the present time that would be a step in the right direction. In general discussion some doubts were expressed as to the probability of getting consumptives to go to the sanatorium, and the question of compulsory notification was discussed. Mr. King gave some particulars of the action taken by the Acton Council, who had arranged terms with the Mount Vernon Hospital Committee, by which they had

the use of three beds at their hospital for consumptive persons. This arrangement had been in operation for 18 months, and, so far as it went, was fairly satisfactory. The difficulty was to get hold of cases of pulmonary consumption in their early stages. It was decided to form a sub-committee to obtain information as to action (if any) taken by various districts, to communicate with the Mount Vernon Hospital authorities, and prepare and circulate full reports to be considered at an adjourned meeting of the association.

The Brighton Quack Case.—A Judge's Comments.

Before Mr. Justice Lawrance, at Sussex Assizes, on Monday, William Henry Hawkins and his son, William George Hawkins, of Kemp Town, Brighton, were indicted for obtaining money by false pretences by selling powders at Brighton. The father pleaded "Guilty," and the case against the son was withdrawn. Mr. Avory, K.C., who prosecuted, said the powders were extensively advertised as being a cure for all manner of ailments. On analysis they were found to be harmless, but were absolutely useless for any of the purposes for which they were advertised. They consisted merely of a mixture of carbonate of soda and bromide of potassium, which might possibly have done some little good to anybody suffering from indigestion. Accused advertised in the name of clergymen who were supposed to have derived benefit from the use of the powder.—The judge, in passing sentence of three months' hard labour, remarked that the prisoner pretended that two persons, whom he described as clergymen, had been to some part of Africa and learnt the secret of this remedy. He wished the Crown success in undertaking prosecutions of this kind, as it was most desirable, in the public interest, that such frauds should be brought to light and put a stop to.

Catholic University School of Medicine.

At a meeting of the Governing Body of the Catholic University School of Medicine held on November 30th, 1906, it was moved by Dr. R. F. Tobin, and seconded by the Rev. J. Darlington, S.J.:—"That the Governing Body desire to leave on record an appreciation of the greatness of the loss sustained by the Medical School, and by Catholic education in Ireland, in the recent demise of the Rector of the Catholic University, the Right Rev. Monsignor Molloy, D.Sc., whose latest act was so generous a benefaction to the laboratories and general equipment of the school. In addition to their regret at the calamity which has befallen the Medical School, the Governing Body desire to express their profound sorrow at the loss of one who was to one and all a close personal friend."

The Amalgamation of the London Medical Societies.

At a meeting of the Clinical Society of London held on November 23rd, Dr. Hale White proposed, Dr. Frederick Taylor seconded, the following resolution, was was carried *nem. con.*:—"That the Council's advice to the Society to join the proposed Union of Medical Societies be adopted." At a joint special general meeting of the Fellows of the Obstetrical Society of London and of the British Gynæcological Society, held at 20, Hanover Square, W., on November 21st, Dr. F. H. Champneys in the chair, the draft report of the Representatives of the Council of the Obstetrical and of the Gynæcological Societies on the amalgamation question, already passed by the two Councils, having been circulated, the following resolution was put from the chair, and carried unanimously:—"That this Joint Special General Meeting of the Fellows of the Obstetrical and of the British Gynæcological Societies agrees to the scheme of amalgamation adopted by the two Councils, and authorises the honorary secretaries to communicate this decision to the honorary secretaries of the Union of Medical Societies, and to notify them that Dr. Champneys has been appointed the Representative of the Obstetrical Society, and Dr. Macnaughton Jones that of the British Gynæcological Society, to serve on the new Committee." A general meeting of the Pathological Society of London was held on Tuesday, December 4th, at 8.30 p.m., in order that the final opinion of the members upon the incorporation of the Pathological Society in the new Royal Academy of Medicine may be ascertained.

A Surgical Cause Celebre.

The action against Mr. J. Lynn Thomas, F.R.C.S., Surgeon to the Cardiff Infirmary, and Mr. Henry E. Skyrme, M.R.C.S., in general practice at Cardiff, which has been brought by a mining engineer, named Southern, to recover damages for alleged negligent treatment by the defendants whereby he lost the use of his arm after an accident, has been proceeding before Mr. Justice Bigham and a special jury for several days, and had not concluded at the time of going to press, so that we are unable to comment on the case. Several eminent surgeons have been called on both sides, including Mr. William Rose, Emeritus Professor of Surgery in King's College, London, Sir Frederic Treves, Mr. Anthony Bowlby, Surgeon to the King's Household, Sir William Bennett, F.R.C.S., Mr. Edmund Owen, F.R.C.S., Sir Thomas Smith, F.R.S., Mr. Waterhouse, F.R.C.S., Mr. H. W. Page, F.R.C.S., Mr. C. W. M. Moullin, F.R.C.S., with the usual affirmative and non-affirmative opinions, which will doubtless be seized upon as an excuse for another onslaught on the differences that exist in professional opinions.

Westminster Hospital.

A quarterly court of governors was held at Westminster Hospital last week, when Sir John Wolfe Barry, a vice-president of the hospital and chairman of the house committee, occupied the chair. A report was presented by the finance committee calling attention to the present financial position of the hospital, which is most serious. Notwithstanding the fact that the expenditure during the current year has been diminished by nearly £1,000, it has been found necessary to borrow the sum of £5,600 from the bankers in order to meet the ordinary expenses of the hospital, and the governors recognise that a strenuous effort must be made to relieve the intolerable strain caused by the present inadequate support. It was announced that the Lord Chancellor had kindly consented to take the chair at a festival dinner, to be held in April next year, with a view to placing before the public the undoubted claims of this the oldest voluntary hospital in London.

A Catheter Difficulty Overcome.

The minor difficulties that attend the preservation of asepsis are so baffling in practice that it is a temptation sometimes to deviate from the strict course. One such difficulty is that of lubricating catheters. After careful boiling, the catheter is apt to be dipped in the traditional oil, which undoes most of the good of the boiling. Messrs. Reitmeyer and Co. have just introduced a preparation from Germany to meet this difficulty. It is called Catheterpurin, and is composed of glycerine with some gum tragacanth and oxycyanate of mercury. Being put up in collapsible tubes, the required quantity can be squeezed on to the catheter without coming in contact with any vessel or other source of contamination. It seems to answer the purpose of an antiseptic lubricant well.

Trinity College, Dublin.

The following candidates passed the final in midwifery, during Michaelmas, 1906:—William Pearson (passed on high marks), Malcolm K. Acheson, Richard G. S. Gregg, Robert E. Wright, George G. Vickery, Henry I. Keane, William S. Tracker, Archibald L. Robinson, Edward C. Stoney, John W. Lane, Frederick Stevenson, John H. Morton, John A. L. Hahn, James C. C. Hogan, Ernest T. Jameson, Langford V. Hunt, Joseph C. A. Ridgway, and Henry P. Hart. The following passed the final in surgery:—John du P. Langrishe (passed on high marks), Thomas O. Graham, Cecil T. Conyngham, Richard Connell, Malcolm K. Acheson, Langford V. Hunt, Francis Casement, Francis O'B. Ellison, William Hutcheson, Theodore C. Somerville, Michael P. Leahy, Percy B. Egan, Henry B. Leech, John H. Waterhouse, Herbert J. Wright, George T. Walton, Dudley F. Torrens, and Charles G. Sherlock.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT MEDICAL LITERATURE.

Action of Sunlight on Milk (*Berlin. Klin. Woch.*, 1906).—Much and Romer announce that the results of their tests have demonstrated that sunlight and oxygen alter the taste of milk after even a brief exposure. They affect the fat in the milk, altering it to a kind of tallowy consistency from oxidation of the fat. Milk thus altered is liable to affect infants injuriously. They advise that milk bottles should be wrapped in black, red, or green paper. The same effects are observed after exposure to sunlight with their perhydrase milk as with ordinary raw milk. Their aseptic perhydrase milk is prepared by treating ordinary milk with peroxide of hydrogen, which sterilises it completely. The peroxide of hydrogen is then eliminated with a "catalase" derived from beef cattle. Milk thus treated seems to keep indefinitely, they state, even without ice. D.

Length of Survival after Onset of Tuberculosis (*Norsk Mag. f. Laeg. Christiana*, 1906).—A committee has been diligently at work since 1904 collecting data in regard to the after-history of persons known to have pulmonary tuberculosis in Norway. Blank circulars were sent to physicians, and reports were received in return of 2,005 cases of pulmonary tuberculosis—905 men and 1,100 women. They show, amongst other points, that out of 2,002 tuberculous patients whose history was traced for four years, 1,094 had died, and 908 were still living, of whom 52.3 per cent. were still able to keep at work. Out of 1,658 whose history was traced for nine years, 1,336 had died by the end of this time, and 322 were still alive, with 67.4 per cent. still able to work. The committee calls special attention to the surprisingly large proportion of the tuberculous with comparatively unimpaired earning capacity after four years. The data further show that the average survival after symptoms of tuberculosis were first observed ranged from 36 to 59 months. D.

Paroxysmal Tachycardia.—Reinhold (*Zeit. f. Klin. Med. Berlin*) reviews the recent literature on the relations between paroxysmal tachycardia and affections of the nervous system, and describes two cases. In one the tachycardia was due to a syphilitic basilar meningitis; in the second to a tumour in the left half of the brain. The findings in the heart were entirely negative in each case. D.

Polycythæmia with Enlarged Spleen.—Bence (*Deut. Med. Woch.*, Berlin and Leipzig, 1906) reports three cases in detail. He treated the patients with repeated venesection, and each time the general condition showed marked improvement; the congestion and headache were relieved. Inhalation of oxygen had a similar effect. He administered daily from 50 to 100 litres of oxygen, after which the patients always felt much better, losing their dizziness. The chief disturbances experienced by the patient are due to the over-filling of the vessels from the extreme viscosity of the blood. In the case of a patient with 7,400,000 reds, six days of oxygen inhalation reduced the number to 6,000,000. The inhalations were kept up for three months, and by the end of a year the number was 4,800,000. In one case Bence restricted the patient to a fluid diet, with good results. D.

The Nucleus Test in Pancreatic Disease.—Dutton Steele (*Univ. of Pen. Med. Bull.*, Nov., 1906) has been investigating Schmidt's test in the diagnosis of pancreatic disease. Schmidt and Wallenfang demonstrated in artificial digestion outside the body that the cell nuclei of muscle are digested by the pancreatic secretion alone, and not by the other digestive ferments. Small balls of meat about the size of a pea were wrapped in a bag of net, hardened in alcohol, and given to the patient. These were recovered from the stools in about 18 hours, a purgative being given if necessary. They were then sectioned and examined microscopically. Schmidt investigated four cases of pancreatic disease, two with complete occlusion of pancreatic duct and destruction of the gland, and two with incomplete closure. In the former cases the nuclei were undigested, in the latter completely digested. In 100 cases of healthy persons and patients with gastro-intestinal disease other than pancreatic, the nuclei were always digested. Experiments with dogs from whom the pancreas had been removed showed that the nuclei in these cases were undigested. Steele's observations verify in the main the contention of Schmidt as to the experiments on dogs, but he holds that the clinical importance of the test is not so great as was suggested by Schmidt. In a case of very extensive pancreatic cancer, the nuclei were digested, and in a case of achylia where there was no pancreatic disease the nuclei were undigested. He sums up by saying:—"The nucleus test is probably a rough indication of the presence or absence of pancreatic secretion, but the relation between the nuclei of muscle and pancreatic secretion may not be specific, and the persistence of nuclei may be the result of general lowering of all digestive power, quite as much as a sign of insufficiency of the pancreas alone." D.

The Physiological Limitations of Rectal Feeding.—Esdall (*Amer. Journ. Med. Sciences*, Nov., 1906) discusses the value of this procedure as a means of supplying food, not as a therapeutic method. The common belief that by this method a very considerable proportion of patients can be maintained on nutritive equilibrium is, he maintains, erroneous, and based on inaccurate observation. That the method has great therapeutic value is not denied. "It is decidedly better than simple starvation; but it is nearly always a marked degree of starvation, and should be recognised as such, and not given a higher place than it deserves." The value of the method depends on several factors. In the first place the local condition, for the treatment of which the method is adopted, is usually considerably benefited by it. The psychical factor is also of great importance, and Pawlow has shown the definite physical effects of such psychical factors. Another reason of the benefit of rectal alimentation is that the patients for whom it is ordered are usually suffering from lack of fluid. Nutritive enemas always contain a large proportion of fluid, and most of this is quickly absorbed, and tends greatly to the benefit of the patient. The salts, too, are in great part absorbed, and are undoubtedly of use in the organism. With regard to the proteids, fats, and carbohydrates, the matter is different; all are to some extent absorbed by the rectum, but much less freely than is commonly thought, and far less freely than when taken by the mouth. From experiments carried on by the writer and Dr. Miller, they found that the value of the food absorbed in their most favourable cases was less than 300 calories in the day, and usually not above 200 calories. "The latter amount is not one-sixth of the absolute demands of most persons, even of most sick persons, if they are to be kept from losing tissue, and especially if they are to have their nutrition improved." The fats, which have an especially high food value, are very badly absorbed; the proteids and peptones are somewhat more easily absorbed, but still only to a

small degree. In the case of the carbo-hydrates, estimation of absorption is of extreme difficulty owing to the bacterial decomposition of the sugars which takes place in the rectum. There is no doubt that in rare instances a larger degree of absorption than this has been observed, and these cases are explained by a reflux of part of the nutritive enema through the ileo-cæcal valve, and absorption in the small intestine. That reversed peristalsis does occur in the large intestine has been established by the observations of Cannon. "The difficulty does not lie in the absence of movements in the large intestine that would carry the food up to the ileo-cæcal valve, but in getting it to pass this valve." "In rare instances considerable amounts of food do actually get by the valve, and small amounts often or even constantly pass through, yet it is quite certain that, as a rule, no considerable proportion succeeds in doing so." Esdall approves Von Noorden's suggestion of using in nutritive enemas some of the end products of proteid digestion, such as amino-acids, rather than the native proteids, and also of the suggestion of Reach to substitute dextrins for other carbohydrates. These appear to be better absorbed, and are much less irritating, and less easily decomposed by bacteria than are the sugars. K.

Transitory Hemiplegia in Elderly Persons.—Edgeworth (*Scottish Med. and Surg. Journ.*, Nov., 1906) describes two cases of temporary hemiplegia which he attributes to "temporary arterial spasm involving a portion of the central vascular supply." In each patient there were attacks of clonic spasm, followed by transitory paralysis, which, on some occasions, were associated with mental derangement, while on other occasions there were attacks of mental derangement only. The plantar reflex was examined for in the second case only, and it did not become of the extensor type. Edgeworth considers that the absence of an extenso-plantar reflex affords a ready means of diagnosing the condition from one of hemiplegia due to some organic cause, where the reflex becomes of extensor type within a very short time. Edgeworth draws the following conclusions in regard to this class of case:—"(1) In elderly persons attacks of transitory hemiplegia may occur, which are probably not due to any persisting vascular lesion. The hemiplegia may or may not be preceded by loss of consciousness or clonic spasm in the subsequently paralysed parts. Or clonic spasm may occur which is not followed by paralysis. (2) If paralysis occurs it may be distinguished from that due to a permanent vascular lesion by the non-occurrence of an extenso-plantar reflex. (3) In such patients attacks of mental derangement, of similar transient character, may occur; they are probaly due to the same cause." K.

The Pancreatic Reaction.—Dr. P. S. Haldane (*Edin. Med. Jour.*, October, 1906), reports the conclusions that he has arrived at with reference to Cammidge's urinary pancreatic reaction, described in 1904. Since that date the writer of the paper has studied the tests, and formulates his results as follows:—(1) The test as a diagnostic aid for pancreatic disease has not proved of any real value, owing to the fact that a positive reaction is often obtained in normal urine. (2) The urine from the same individual (normal) may yield at different times negative, equivocal, or well-marked results. (3) The occurrence of crystals is largely affected by the degree of concentration of the fluid at the end of the process. (4) In the guinea-pig's urine crystals are obtained in every case, no concentration being required. (5) The inhibition of glycerine has very little effect on the reaction. (6) Differentiation in pancreatic disease by tests A and B (Cammidge) frequently leads to a wrong diagnosis. (7) The use of lead in the test is an additional source of fallacy, though not a very important one. M.

Tumours of the Frontal Region of the Brain.—The diagnosis of tumours of this region is discussed by Grainger Stewart (*Lancet*, Nov. 3rd, 1906). He points out in the first place that these tumours are generally characterised by an absence of signs pointing to involvement of other parts of the brain, rather than by definite focal signs. The general signs of intracranial tumour are, however, present. Optic neuritis is nearly always present, and in his experience it almost always appears first in the eye on the side of the growth, and is also most intense on this side. Mental symptoms may occur, but are not always due to the position of the tumour. When, however, the main changes are inattention, lack of concentration, and slowness in answering questions, they may be directly ascribed to disease of the frontal region. Fits and seizures which are never ushered in by sensory aurae are also commonly met with, and often resemble ordinary epileptiform attacks. As more direct diagnostic aids, he mentions unilateral anosmia, unassociated with nasal disease; tremor in the limbs of the side homolateral to the tumour, and most marked in the arm; diminution of the superficial abdominal reflex on the contralateral side; contralateral hemiparesis and contralateral extensor response on stimulating the sole of the foot; and, lastly, local external signs such as cranial tenderness and protrusion of the eye. M.

Formic Acid in Diphtheria.—Dr. Croom reports the results obtained by the treatment of 100 cases of diphtheria by formic acid (*Edin. Med. Journal*, Oct., 1906). He was led to give it as a general tonic, owing to the fact that the formates in general produce their musculo-tonic effect without having much action on the blood pressure, and thus contrast strongly with the more commonly-used drugs, strychnine, digitalis, and adrenalin. In every case the anti-toxin treatment was carried out as usual, but, in addition, from 5 to 20 minims of a 25 per cent. solution of formic acid was given four-hourly for ten to fourteen days, and then 5 to 10 minims three times daily for a further period of fourteen days. For purposes of comparison he has analysed 300 other cases, and finds: (1) that the percentage of death from cardiac failure in the cases treated by formic acid was 2 per cent.; in those not so treated 8.6 per cent. (2) that the percentage of paralyses was 3 per cent. in the treated cases, and 14 per cent. in the non-treated; (3) that albuminuria was much less common in the cases which took formic acid than in those which did not. The conclusion that the author derives is that a good case has been made out for the value of formic acid, and he strongly counsels its further use. M.

Gastrostaxis.—Under this title Dr. Hale White draws attention to cases of hæmatemesis caused by capillary oozing from the mucous membrane of the stomach, and usually confounded with cases of true ulceration (*Lancet*, Nov. 3rd, 1906). His attention was first called to it by the admission of a patient to Guy's Hospital suffering from severe and ultimately fatal hæmatemesis, and in whose stomach no trace of ulceration was found at the autopsy. On then studying the subject he was struck by the fact that post-mortem evidence shows gastric ulcer to be as common in men as in women, while the usually accepted symptoms of ulceration are much more often found in women. From this he concludes that many cases of so-called gastric ulcer in women are really examples of gastrostaxis, and in support of his thesis he adduces the clinical records of 29 cases in which the stomach was either examined during life by operation, or *post mortem*. Of the 29 patients, 27 were women, and in all the principal symptoms were recurring severe hæmatemesis and dyspepsia. In considering the etiology he excludes the theory of vicarious menstruation, and also states that some of his patients showed no signs of chlorosis. As a result also of pathological evidence, he concludes that gastric ecchymoses and hæmorrhagic erosions are not definitely connected with the disease. The prognosis is good when an operation is not performed, and the treatment simple, this last consisting of the usual treatment for gastric ulcer, with, however, an early return to gastric feeding. M.

NOTICES TO CORRESPONDENTS &c.

☞ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to 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 proofs.

SUBSCRIPTIONS.

SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance.

DR. H. S. T.—It is important to exclude the possibility of chronic osteomyelitis of the lower end of the femur. This condition is liable to give rise to mistakes in the diagnosis of sarcoma, and should be seriously considered. An exploratory incision is quite proper treatment if X-rays and clinical examination fail to establish the diagnosis.

C_2H_6O.—The question of intoxication and its mechanism is as complicated as it is interesting. The toxic properties of the higher alcohols are proportional to their solubility and volatility. Natural wine containing comparatively few higher alcohols will seldom lead to chronic alcoholism. Absinthe and beer and so on produce a mixed intoxication, that in the case of absinthe being complicated by the convulsive action of oil of wormwood on the cerebrum. Ether intoxication is of a separate character.

M. H.—The name of the disease is probably sclerema neonatorum, if the hardness of the skin is as you describe.

DOVER.—Certainly. It would appear from Clause XVI. of the Central Midwives Board rules that midwives may administer poisonous drugs, for the rule runs that "The midwife must enter in a book . . . all occasions on which she is under the necessity of administering any drug, whether scheduled as a poison or not. . ." We do not know how one enters an "occasion" in a book.

DR. MONRO'S "Cases of Œsophageal Strictures" are marked for early insertion.

MR. F. B. M. (Hastings) is thanked for his letter, but the case is one of almost daily occurrence, and not worthy of special reference.

DR. ARANY (Budapesth).—It will afford us pleasure to receive it.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, DECEMBER 5th.

OBSTETRICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8 p.m.: Specimens will be shown by Dr. Handfield-Jones, Dr. H. R. Spencer, Mr. J. H. Targett, and Dr. W. A. Potts (introduced by Dr. Stevens). Paper:—Dr. V. Bonney: The Treatment of Ovarian Prolapse by shortening the Ovarian Ligament.

SOCIETY OF ARTS (John Street. Adelphi, W.C.).—8 p.m.: Colonel Sir C. M. Watson, K.C.M.G., C.B.: The Metric System.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Dr. C. Ryall: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Dr. E. F. Buzzard: Syphilis in the Nervous System.

THURSDAY, DECEMBER 6th.

NEUROLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street, Cavendish Square, W.).—8.30 p.m.: Exhibition of Clinical Cases. Patients in attendance at 8 p.m.

NORTH-EAST LONDON CLINICAL SOCIETY (Tottenham Hospital, N.).—4 p.m.: Discussion on Notes from a Children's Clinic (opened by Dr. Reginald Brown).

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.)

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m.: Chesterfield Lecture:—Dr. M. Dockrell: Fungous Diseases of the Hair: Hyphogenic Sycosis; II., Tinea.

HARVEIAN SOCIETY (Stafford Rooms, Titchborne Street, Edgware Road).—8.30 p.m.: Discussion on the "Modern Methods of Dealing with Ordinary Cases of Labour." To be opened by Dr. Robert Boxall, Dr. Horrocks, Dr. Handfield Jones, and others will take part.

FRIDAY, DECEMBER 7th.

WEST KENT MEDICO-CHIRURGICAL SOCIETY (Miller Hospital, Greenwich Road, S.E.).—8.45 p.m.: Purvis Oration:—Dr. A. M. Robson: Operative Treatment of Acute General Peritonitis. Conversazione.

LARYNGOLOGICAL SOCIETY OF LONDON (20 Hanover Square, W.).—5 p.m. Exhibition of Cases and Specimens.

SOCIETY OF ANÆSTHETISTS (20 Hanover Square, W.).—8.30 p.m.: Papers by Dr. Ll. Powell, Dr. G. H. A. Barton, M. A. de Prenderville, and Mr. L. K. Thomas.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.:—Dr. L. Lack: Clinique. (Throat.)

TUESDAY, DECEMBER 11th.

MEDICO-LEGAL SOCIETY (22 Albemarle Street, W.)—8.30 p.m.: I., Exhibition of Medico-Legal Specimens. II., Discussion, "Some Limitations of Medical Evidence." To be opened by Stanley B. Atkinson, M.B., J.P.

Vacancies.

Monkstown Hospital, Co. Dublin.—Qualified Resident Medical Officer. Salary £40 per annum, with board, &c. Immediate application to Hon. Secretary. (See advt.)

Manorhamilton Union.—Temporary Medical Officer. Four guineas per week. Immediate application to Peter Kearnig, Clerk of Union. (See advt.)

The Grafton Club, Dublin.—Medical Officer. Applications to Hon. Sec. on or before Dec. 12th. (See advt.)

Royal Hospital for Incurables, Donnybrook, Dublin.—Resident Medical Officer. Salary £120 per annum, with board, &c. Immediate application to J. J. Thompson, Registrar. (See advt.)

Fisherton Asylum, Salisbury.—Second Assistant Medical Officer. Salary £120 per annum, with board, apartments, and washing. Applications to the Medical Superintendent.

The Middlesex Hospital, W. Medical Officer and Registrar to the Cancer Department. Salary £100 per annum, with board and residence. Applications to F. Clark Melhado, Secretary Superintendent.

Bristol General Hospital.—Senior House Surgeon. Salary £150 per annum, with board, residence, &c., in the house. Applications to the Secretary.

Glamorgan County Asylum, Bridgend.—Junior Assistant Medical Officer. Salary £150 per annum, with board, apartments, attendance, and washing. Applications to the Medical Superintendent.

Manchester Royal Infirmary.—Resident Medical Officer. Salary £150 per annum, with board and residence. Applications to the Chairman of the House Committee.

Blackburn County Borough.—Education Committee.—Assistant to the Medical Officer of Health. Salary £150 per annum. Applications to Alexander Gow, Director, Education Offices, Library Street, Blackburn.

Appointments.

BAYLEY, HARRY, L.S.A., Assistant Medical Officer to the Warkeford Hospital for Mental Diseases, Oxford.

DODD, STANLEY, M.B., B.C.Cantab., Obstetric Tutor at Westminster Hospital.

FEDDEN, W. FEDDE, M.S., M.B., F.R.C.S.Eng., Assistant Surgeon at St. George's Hospital.

GEAKE, G. B., L.D.S.Eng., House Surgeon to the Royal Dental Hospital of London and London School of Dental Surgery.

GRANT, J. DUNDAS, M.D., F.R.C.S.Eng., Surgeon to the Throat and Ear Department of the Hospital for Consumption, Brompton.

JACKSON, H. E., L.D.S.Eng., House Surgeon to the Royal Dental Hospital of London and London School of Dental Surgery.

KIDD, PERCY, M.D., F.R.C.P.Lond., Consulting Physician to the Hospital for Consumption, Brompton.

PITTS, A. T., L.D.S.Eng., House Surgeon to the Royal Dental Hospital of London and London School of Dental Surgery.

ROBERTSON, W. G., M.B., Ch.B.Edin., House Surgeon at the Hartlepools Hospital.

SIMPSON, W. B., M.B., M.S., D.P.H.Aberd., Medical Officer of Health of Grimsby.

SOUTHERN, W. D., L.D.S.Eng., House Surgeon to the Royal Dental Hospital of London and London School of Dental Surgery.

STEVEN, J. LINDSAY, M.D.Glasg., F.F.P.S.Glasg., Visiting Physician to the Western Infirmary, Glasgow.

WALL, R. CECIL B., M.D., B.Ch.Oxon., Assistant Physician to the Hospital for Consumption, Brompton.

WHALLEY, FREDERICK, M.D., Ch.B.Leeds, House Surgeon at the Leeds Hospital for Women and Children.

Births.

AUBREY.—On Nov. 28th, at Bitton, Bristol, the wife of Thomas Aubrey, M.B.Lond., of a son.

HADFIELD.—On Dec. 1st, at Mornington, Malvern Link, the wife of C. F. Hadfield, M.A., M.D. (Cantab), of a daughter.

HALAHAN.—On Nov. 28th, at 11, Stoke Terrace, Devonport, the wife of Staff-Surgeon T. J. Halahan, R.M., H.M.S. Diadem, of a daughter.

MARSHALL.—On Dec. 1st, at St. John's House, Lechlade, Gloucestershire, the wife of Thomas Bingham Marshall, M.R.C.P., L.R.C.P., of a son.

ROSS.—On Nov. 27th, at "Grange House," Burslem, Staffordshire, the wife of Wm. Levingston Ross. L.R.C.S. and L.R.C.P.I. of a daughter.

SELBY.—On Nov. 27th, at The Rock, Frodsham, Cheshire, the wife of T. J. Selby, M.B., of a son.

STONE.—On Nov. 27th, at 30, Nivern Square, South Kensington, the wife of Surgeon-Major C. A. Stone, R.A.M.C., of a son (stillborn.)

Marriages.

LATHAM—BAKER.—On Nov. 27th, at St. Martin's Church, Lincoln, Charles Hugh Latham, M.B., B.S.Lond., youngest son of the late Rev. E. Latham, M.A., Vicar of Matlock Bath, to Margaret Emily De Foe, only daughter of the late Canon W. De Foe Baker, Rector of Snelland.

PESEL—SWAIN.—On Nov. 29th, at St. Mary-at-the-Elms, Ipswich, Howard G. Pesel, M.D., of Thornton-le-Dale, Yorks. son of the late George Pesel, Huddersfield, to Florence Mary, eldest daughter of the late William J. Swan, Canterbury.

Death.

ROBERTS.—On Nov. 29th, at Broadstairs, John Coryton Roberts, L.R.C.P., M.R.C.S., L.M., of Avenue House, Peckham Rye, aged 65 years.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIII. WEDNESDAY, DECEMBER 12, 1906. No. 24

NOTES AND COMMENTS.

The New Direct Representatives.

WE are officially informed that Dr. Langley Browne, Dr. McManus, and Dr. Latimer, have been elected as Direct Representatives on the General Medical Council for England, and Dr. Norman Walker for Scotland. The exact figures were not obtainable at the time of going to press.

The Proposed State Medical Service for Ireland.

A CONSIDERABLE amount of misapprehension appears to have arisen in the minds of some members of the Poor-Law Service in Ireland as to whether or not the proposals for reform of the Association are intended to apply to Dispensary medical officers. Some of this misunderstanding, we fear, has been wilfully encouraged with the object of casting discredit on the scheme, whilst more of it is genuine. The position of the matter is perfectly plain, and is this. The terms of reference of the Commissioners were limited, and did not include any reference to Dispensary Medical Officers. At the same time, the Commissioners saw that it was impossible for them to recommend any satisfactory scheme which did not include reform in the Dispensary system, and consequently they brought that system into their report by implication, and in such a manner as to make their intentions perfectly plain. It was never present in their minds that the reformed Workhouse and Infirmary medical system should alone be constituted a State service, and we can say in the most definite manner possible, and without fear of contradiction that their report advises and that they themselves intended inclusion of the Dispensary Service.

Edinburgh Cavalry.

THE way of the sanitarian is hard at the best of times, and people have yet to give the first consideration to questions of health. We cannot help sympathising with Mr. Haldane in the unpopularity he has incurred in Edinburgh through his concern for the health of the Scots Greys. For years medical men have been urging on the military authorities the paramount importance of disease-prevention if a little British Army is to go the proverbially long way, and with new men at the War Office a sprinkling of new ideas has come in and the soldier is beginning to find his "fitness" regarded as an essential element in his training. We who hope that this care may be still further extended cannot help regretting that the removal of the Scots Greys from the insanitary Piershill Barracks should be used as a stick to belabour the Minister for War. It is true that some experts are said to have pronounced the barracks in good sanitary condition; but Mr. Haldane has to be guided by Sir Alfred Keogh's advice, and his decision is strongly against the barracks. However, another consultation as to the condition of the barracks is to take place, and we can only hope that if the adverse opinion is sustained the patriotism of the good folk in Edinburgh will show itself by preferring healthy soldiers in England to unhealthy ones in Scotland, even though they be mounted on horses.

Clacton Doctor's Case.

WITH regard to the Clacton medical man to whose case we recently called attention, we have received from a well-known member of the profession, himself a magistrate for the town, a communication and a newspaper cutting which we have read with great interest. It will be remembered that the medical man of whom we wrote was charged and convicted of extraordinary conduct, and we expressed the opinion that an inquiry into his mental state should be made. We now learn that such an enquiry was made by two medical practitioners last September, and that he was pronounced sane. However, only last week the same gentleman was again before the bench, charged with being drunk and disorderly in the highway, and was unanimously found guilty of the offence. The Chairman, however, announced a decision of the magistrates with regard to his treatment which causes us great satisfaction. The defendant was remanded on bail for a fortnight, in order that the Home Secretary might be communicated with for instructions as to how to deal with him. We can only compliment the bench on their high sense of duty and responsibility, and this we do heartily.

Objection to Doctors.

MEDICAL men have to court unpopularity at times when their duty demands it, but it is rather a shock to learn that a man will for years suffer excruciating pain and even try to commit suicide rather than see a doctor. Such, however, was the case with a man aged seventy-two who was charged at the Clerkenwell Sessions last week with trying to commit suicide, and who pleaded guilty to the charge. The malady, the nature of which was not revealed, was a most distressing one, and for seven years he suffered till he could bear it no longer, and one morning he was found in bed with his throat partially cut. Fortunately for him a medical man was sent for, and succeeded in saving his life and alleviating his pain, so that the prisoner was subsequently in Court able to express sorrow for his folly. There are a certain number of people who —in health—boast that they would rather die than

see a doctor, but when the alternative presents itself, in our experience, they invariably choose the latter.

Associated Midwives, Unlimited.

COMBINATION is the order of the day, and far be it from us to decry the advantages to be derived therefrom, but we confess to feeling a little surprise on learning that the midwives of Manchester are enrolling themselves into a fighting force. We do not know what the grievances of midwives are: whether they object to calling in a medical man in difficult cases, or whether they regard the Manchester Supervising Authority as tyrannical in its administration. For ourselves we should have thought the midwives have had everything so much their own way that their lines would have been regarded as having fallen in pleasant places, but presumably we are in error. It seems that the Women's Trades' Council have taken the matter up, and have lent their rooms for the purpose, so that we presume midwives are going to regard themselves as "tradeswomen," and not as "professional ladies." And for that relief let us be truly thankful.

LEADING ARTICLES.

THE JOINT HOSPITAL CONFERENCE AND HOSPITAL REFORM.

THE awakening of the general practitioner, slow and partial though it be, is already bearing fruit. On December 6th a Conference representative of medical charities from all parts of the United Kingdom met together in London at University College. This important meeting had been organised by the Hospitals Committee of the British Medical Association, as the outcome of a serious attempt to grapple with the injury wrought upon the rank and file of the medical profession by the indiscriminate distribution of hospital relief. The movement, therefore, must be welcomed by every one who is interested in the future prosperity of a learned and humane profession, whose members now find themselves plunged into a morass of adversity due to causes of which that of unfair hospital competition is not one of the least important. From many points of view last week's Conference proved nothing more than the complexity of the whole question of hospital reform. As usually happens in medical politics, the engineering of the whole matter had fallen into a few hands, representing interests that could not be regarded as identical with those of the general practitioner. The chair, for instance, was occupied by Sir William Church, ex-President of the London Royal College of Physicians, a body that is absolutely autocratic and aloof from the faintest suspicion of modern democratic thought and progress. Then the chief resolution was moved by Sir Henry Burdett, an amiable gentleman whose name has long been honourably connected with charitable administration throughout the kingdom. It is not easy to see, however, why the weight of his non-medical authority should be suddenly thrown into the balance, and why he should claim to represent and protect the rights of medical practitioners. The Conference whom he addressed appeared to hold that view precisely. It fell to Sir Henry Burdett to move a general approval of the principles formulated by the Joint Committee. This he proceeded to do by an admirable and well-informed statement of the disproportionate growth of charitable medical relief during the past generation, but he said little about the principles that the meeting was asked to adopt. The significance of that statement may be gathered from the fact that there were no less than nineteen suggested model principles of hospital management, covering most of the burning questions involved in the relations of the medical charities, the public, and the profession. It seems an extraordinary proceeding, therefore, to summon a Conference, which it is proposed to hold annually, and to ask them at the outset to pledge themselves to an explicit policy drawn up in detail by a committee that must be regarded for that particular purpose as private and unofficial. Under these circumstances, it is little to be wondered at that the Conference refused to sign a blank cheque of this kind, and Sir Henry Burdett's resolution was hailed with a chorus of criticism and dissent. One speaker, for example, asked if the Conference was to pledge itself for all time to Principle XIII., which laid down "that though there is no objection to pay wards being connected with voluntary hospitals, provided that they are open to every member of the medical profession, who shall be paid any fee to be arranged by him and his patient." Even with the appended qualification, the objections to the pay system in hospitals are deeply rooted, and many medical men regard its adoption by Guy's, by St. Thomas's, and by various other general hospitals as an indelible blot upon their administration, and an unceasing injury to the general practitioner. Yet Sir Henry Burdett appeared to take it for granted that Section XIII. would secure the instant and hearty approval of every member of the Conference. The result of the discussion was the withdrawal of the original resolution pledging the Conference to accept a parcel of cut and dried principles, and the substitution of a declaration that they would "welcome the further discussion of the principles" laid before them. This result looks like a spirited attempt on the part of the hospital delegates to think and act for themselves. It is significant that Sir William Church, Sir Henry Burdett, and one or two of their supporters more than hinted their desire for an extended system of provident dispensaries. This proposal should be regarded with the closest scrutiny by the medical profession. Unless properly safeguarded, it would mean merely the substitution of one form of abuse for another. Assuming that general practitioners are appointed as medical officers to such dispensaries, it would simply mean the payment of a privileged few at the expense of the many, who would at the same time be deprived of a certain number of patients. The way in which professional philanthropists insist on the necessity of extracting money from

poor hospital patients is a thing to marvel at. They appear to overlook the obvious fact that the proper course is to curtail and control the present distribution of charity. To reduce the enormous volume of gratuitious medical relief by restricting it to the deserving poor is the last thing they propose. Their constant effort seems to be to extract larger and larger sums from the hitherto apparently almost inexhaustible stream of public benevolence. But the time has come when the heart must be governed by the head, and the bitter cry of the general practitioner has gone forth in unmistakable tones to the outside world. Under these circumstances we welcome the first Joint Hospitals Conference of Great Britain as a presage of a brighter future in the administration of our hospital system, which, after all, stands an enduring monument to the sweet humanity that lies deep in the heart of mankind.

CARDIFF SURGEONS' CASE.

The action for £2,000 damages for negligence in surgical treatment brought by Mr. Southern of Cardiff, against Mr. Lynn Thomas and Mr. Skyrme, ended last week in a verdict for the plaintiff with £100 damages. The case was tried at the Glamorgan Assizes a year ago with an indeterminate result, for the jury then were unable to agree; this time the *venue* was changed to the High Court, where Mr. Justice Bigham with a jury heard the case. The plaintiff in the action was a mining engineer, who in July, 1904, as the result of a bicycle accident, sustained certain injuries, the chief of which was one to the right shoulder. He called in Mr. Skyrme, a general practitioner at Cardiff, who diagnosed a sub-glenoid dislocation of the humerus, which he reduced by putting his foot in the axilla and pulling on the forearm. Mr. Skyrme, in the course of his examinations and manipulations, found further trouble and called in Mr. Lynn Thomas. Together they diagnosed a fracture of the surgical neck of the humerus, but in consequence of the extensive bruising of the soft parts which had occurred, they decided that, in view of the danger of gangrene, no further treatment than placing a pad in the axilla and bandaging the upper arm to the side would be justifiable. As a matter of fact, great swelling of the arm subsequently occurred, and when a Röntgen ray photograph was afterwards taken, it was found the fragments of the bone overlapped and were becoming joined by side-to-side and not end-to-end union. The lower fragment was drawn upwards and inwards into the axilla, while the upper fragment was pulled outwards. To cut a long story short, the patient recovered with a good deal of stiffness of the shoulder, which, considering the extensive damage to the soft parts and the subsequent adhesion, was not surprising. The case tried in London was long drawn out, and considering that Mr. Rose, Mr. Pepper, and Mr. Battle gave evidence for the plaintiff, and Mr. Bowlby, Sir Frederick Treves, Mr. Mansell Moullin, Sir William Bennett, Mr Arbuthnot Lane, Mr. Page, Mr. Edmund Owen, and Mr. Waterhouse for the defendant, it cannot be said that the jury lacked the opportunity of deriving information as to the propriety of the treatment. However, after an hour's consultation they reported that they could not come to a unanimous decision, and on being sent back by the judge, they reported after another half-hour that they were still not entirely agreed; again the judge sent them back, and after further hesitation they sent a note into Court, raising a question which practically amounted to asking direction from the judge as to their verdict. Finally, after being repeatedly urged by the judge to come to a decision, they found for the plaintiff with £100 damages. Naturally the defence applied for a stay of execution with a view to appeal, and after some argument this was granted on certain conditions. The case standing thus at the time of writing, we are precluded from commenting on it as we should like to do. It is a matter of vital concern to medical men in every branch of practice that treatment deliberately adopted by a well-equipped general practitioner in consultation with an eminent hospital surgeon should be regarded as "negligent" by a jury, and this result, if allowed to stand, raises serious questions as to the relation of the profession to the public. Of this we shall have more to say later. At present it is pertinent to point out that the costs of this action are bound to be of ruinous dimensions. Taking the figures suggested by a leading Welsh newspaper, it seems the necessary expenses will be some £5,000 or £6,000, and when the untaxed costs between solicitor and client are taken into account, they will reach some £8,000. We are not prepared to support these figures as given, but that the total will be prodigious is certain, and it must be remembered that this is the second trial.

NOTES ON CURRENT TOPICS.

Lunacy and Public Health.

The rather curious step lately taken by the Government with regard to the Royal Commission on the Care and Control of the Feeble-minded, namely, extending the reference in the middle of their sittings so as to bring general lunacy administration under their investigation has of course immensely increased the scope of their enquiries. It may not have been an altogether convenient method of procedure, but the need for enlarging the Lunacy Commission, or otherwise dealing with the central administration of the lunacy laws was urgent. At the sitting last week Sir James Crichton-Browne gave evidence of an interesting character, and those of the Royal Commissioners who are possessed of an imagination should find his suggestions, in one respect at least, worthy of deep reflection. While opposed to any co-ordination of the functions of the Lord Chancellor's Visitors and the present Commissioners in

Lunacy, Sir James proposed as an ideal that there should be a Board of Health, with its own Cabinet Minister, which should embrace in its purview the care and treatment of the insane, and, moreover, pursue investigations into the factors that conduce to insanity. It will probably come to the lay public as a surprise—indeed it has already done so if we judge from the expressions we have seen—that mental disease is disease that should be treated in conjunction with and on similar lines to bodily ailments, and that it is amenable to preventive treatment. Lunacy is still regarded as a legal status and not as a cerebral affection, and the surest way to secure proper conceptions with regard to it in the public mind would be to remove lunacy treatment altogether from the Lord Chancellor's department, and to bring it into line with public health administration.

Medical Men and Money-Lenders.

The persistency with which money-lenders circularise the medical profession is a sad comment on the welfare of some of our weaker brethren. Like any other form of advertisement, it would not be sustained over a long period of time unless it proved remunerative. Medical practice, especially in the present days of remorseless competition, is apt to drive unfortunate practitioners through penury into the nets of usury. Last week's bankruptcy records revealed the case of an Essex medical man who had become involved in the coils of that most venomous hydra, the Hebrew money-lending solicitor. It is somewhat a matter of wonder that the Incorporated Law Society permit members of the legal profession to embark in such transactions. However, in this particular instance the borrower appears to have been alive to the sharp practices to which he was subjected in his anxiety to raise various loans. The question of usury as it affects the public has never been firmly handled by the legislature. When that desirable attitude is attained by Parliament we may hope that the issuing of undesirable circulars, such as those of patent medicine vendors, racing tipsters and money-lenders may be prohibited under heavy penalties.

Gratuitous Medical Certificates.

Were the medical profession to protest with united action against the granting of certificates without fee they would speedily gain their point. In the case of school boards an immense number of certificates are obtained from medical men without payment. This mistaken policy is often the result of sheer kindness on the part of medical attendants, who are unwilling to put poor people to unnecessary trouble or expense. Obviously the School Board, maintained at the expense of the ratepayers, should pay a reasonable fee for the certificates that enable them to exercise an adequate control over the attendances of scholars. At Acocks Green Police-court, Birmingham, last week in a non-attendance case an inspector asked why Dr. Ganner, a medical man, wanted the Education Committee to pay for a certificate. The gentleman referred to based his refusal upon the fact that the certificate was wanted by the Education Committee and not by the parents. Therefore the former should pay a fee for his services. The boy had not attended school on his advice, as he was ill. He advised the school inspector to try and get an expression of opinion from a solicitor for nothing. The case was dismissed, and the refusal of Dr. Ganner was thereby justified. If all medical men would agree to refuse school certificates without pay the point would have to be conceded. This matter would be worth the attention of the General Medical Council, had they any time to spare for so plain and prosaic a duty as the protection of the rights of the medical practitioner.

The Anæsthetist's Responsibilities.

IN France some months since, the relatives of a man who had died under chloroform brought an action against the medical man who administered the anæsthetic, claiming £2,000 damages. The claim was based on the fact that he had not warned the deceased, an alcoholic, of the possibility of a fatal result. It was not even suggested that the administration was in any respect faulty, but it was urged that it was imprudent to give chloroform to a man who was notoriously alcoholic and had fainted twice shortly before the operation. The Court of First Instance at Chateau-Thierry awarded £320 by way of damages on the grounds (1) that the patient being an alcoholic rendered the administration of chloroform peculiarly dangerous; (2) that his condition was not such as to place his life in danger; and (3) that under these circumstances he ought to have been warned of the possibility of a fatal issue. This decision naturally created much perturbation among practitioners, and an appeal was at once entered. Judgment has just been rendered by the higher Court of Amiens quashing the previous decision. The "motives" prompting the revision are worth recording: The Court declined to admit that alcoholism constituted a contra-indication for administering chloroform, seeing that it was a common practice in the Paris hospitals in urgent cases to give it to workmen even actually under the influence of alcohol. The fainting, declared the judges, was no doubt due to the pain caused by the movement of the damaged arm, and in no wise proved any inherent tendency to syncope. With regard to the allegation that an anæsthetic ought not to be given unless the patient's state is such as to threaten life, the Court state that the view "is not one which can be seriously advanced" in view of the absurd restrictions which such a decision would place on the use of anæsthetics in general, seeing, moreover, that chloroform lessens rather than increases the risk of syncope by abolishing pain, which would entail greater danger than the infinitesimal risk attached to the inhalation of

chloroform. Lastly, with regard to the fact of the doctor not having warned his patient of the risk, the Court point out that the danger of chloroform appears to lie more particularly in the impressionability of the patient, consequently that any such warning would infallibly have materially enhanced the risk. On the contrary, the doctor's duty is to reassure his patient, and not to alarm him unnecessarily. The Court added that the patient was evidently cognisant of the fact that he was running some risk seeing that he said to a friend who was present, "You will go to my funeral after all." It is a pleasure to record a judgment so intelligently "motivated" and one shudders to think of the disastrous consequences that would have accrued to suffering patients had the foolish decision of the first Court been upheld.

Clay Poultices made in Germany.

A weird story of unqualified medical practice comes from Bath. It appears that the four-year-old daughter of a banker was lying ill in that ancient city The father telegraphed from Egypt to a non-medical assistant at a consumptive home in Germany, named Eickche, to go and attend the child at Bath. When he arrived the local medical man naturally retired from the case. Two trained nurses were left, and one of them stated that under Eickche's directions she applied to the patient's chest poultices made of clay taken from the garden, put on cold, between muslin. These poultices were kept on two hours, until they became quite hot. The child also had cold baths, gradually increased to six in a day. When the day was bright the child was placed in a sunny spot in the room, undressed and lying in its cot. This line of treatment was not unnaturally brought to a speedy end by the death of the patient, and Eickche has fled the country. If unqualified medical practitioners are wanted, surely there are enough of them here at home without sending for them to Germany. The laws of the United Kingdom demand a long and costly training, and stringent examination tests before any person is permitted to practise as a medical man. Yet any quack may fleece the public right and left and acquire huge sums of money by fraudulent cures of the clay poultice order.

PERSONAL.

H.R.H. the Duke of Connaught, K.G., has graciously accepted the position of one of the Vice-Patrons of the North London or University College Hospital.

Sir Edwin Galsworthy, who has been connected with the Metropolitan Asylums Board since its establishment forty years ago, and for several years past as its chairman, has now resigned, to the great regret of his colleagues.

Dr. Thomas John Carson has been appointed Coroner for the borough of Oldham. He was Mayor of the borough last year, and resigned his office of Alderman in order to be eligible for the post of Coroner.

An unfavourable report is given of Dr. Hébert, whose condition is causing grave anxiety to his medical attendants at the Paris Hospital.

Sir Joseph Fayrer, Bart., Physician Extraordinary to the King, celebrated his 82nd birthday on December 6th.

Dr. Nuttall has resigned the Readership of Hygiene in the University of Cambridge, and it is recommended that a Lectureship of Hygiene be instituted.

Dr. MacAlister, Dr. Humphry, and Dr. Barclay Smith have been appointed members of the Cambridge University State Medicine Syndicate for three years.

Lieutenant-General W. H. Douglas, C.B., will inspect the Volunteer Ambulance School of Instruction for London and the Eastern District and present the prizes on December 12th.

The 1907 annual meeting of the British Medical Association will be held at Exeter, under the Presidency of Dr. Pavy, Senior Physician to the Royal Devon and Exeter Hospital. The last visit of the Association to that ancient city was in 1871.

The address on "Surgery" at the Exeter meeting will be delivered by Mr. Butlin, and that on "Medicine" by Dr. Hale White.

A stay of execution has been granted in the case of Southern v. Skryme and Lynn Thomas, so that more may yet be heard of this long and costly litigation.

The Hughlings Jackson lecture before the Neurological Society was delivered by Sir Victor Horsley on "Recent Research on Dr. Hughlings Jackson's Views on the Function of the Cerebellum."

The result of the election of a direct representative for Scotland on the General Medical Council was declared on Saturday. Dr. Norman Walker, Edinburgh, was elected by a majority of 429 votes over his opponent, Dr. William Bruce, of Dingwall.

Sir Richard Douglas Powell (President of the Royal College of Physicians), Mr. Henry Morris (President of the Royal College of Surgeons), and Dr. Kingston Fowler (Dean of the Faculty of Medicine of the University of London) were entertained at a congratulatory dinner on the 4th inst., at the Café Royal, by their colleagues of the Middlesex Hospital. Mr. Andrew Clarke was in the chair.

Dr. D. J. Coffey, Professor of Physiology in the Catholic University School of Medicine, Ireland, has been appointed Dean of Faculty of the School for the coming year, in room of Sir Christopher Nixon, who vacated the post on his appointment as Vice-Chancellor of the Royal University of Ireland.

The Manchester Port Sanitary Authority have agreed to ask the Board of Trade to appoint Dr. Dearden as medical officer under the new Merchant Shipping Act.

Dr. C. A. Ball has been appointed surgeon to Sir Patrick Dun's Hospital, Dublin, in place of Professor E. H. Bennett, who has resigned.

The leave of absence of Dr. G. A. Finlayson, Pathologist of the Medical Department, Singapore, has been further extended for two months from the 11th instant.

A CLINICAL LECTURE ON CHOLELITHIASIS.

By WILLIAM TAYLOR, M.B., F.R.C.S.I.

Surgeon to the Meath Hospital and County Dublin Infirmary; Member of the Council, Royal College of Surgeons, Ireland.

GENTLEMEN,—The patient before us was sent to me by Dr. David Jackson. The history of her illness is shortly as follows:—For some thirteen or fourteen years past—she is now 41 years old, married, and the mother of nine healthy children—she had been complaining of that condition which is commonly, yet somewhat vaguely, described as indigestion. She was seldom free from discomfort, but at times she experienced intense pain which started in the upper part of her abdomen—as she described it, in the pit of her stomach: that is, the epigastrium—and radiated thence round the right side and into the back of the right shoulder. When asked to show where she felt the pain in the back, she placed her hand over the lower portion of the right scapula.

Several times in the early period of her illness she has been confined to bed for three or four days at a time, and on a few occasions for a week or two. During the past four years she would be a week or ten days in bed and then up for a similar period, so that she was becoming a confirmed invalid. Quite recently she came to live on this side of the Liffey, and sent for Dr. Jackson to see her for the first time a few days before her admission here.

Dr. Jackson very correctly diagnosticated the cause of her trouble at his first visit, and suggested she should place herself under my care. Her condition on admission was that of a moderately well-conditioned woman. The skin was quite clear and the eyes bright. Though then free from severe pain, she experienced a slight dragging sensation and felt a sense of discomfort in her epigastric region. On palpation of the abdomen, the only abnormality to be detected was a slight amount of rigidity of the upper third of the rectus muscle on the right side, and some degree of tenderness on deep pressure immediately below the right costal arch. On sinking the fingers deeply underneath the right costal arch, and asking the patient to take a deep inspiration, at first she seemed to breathe freely and easily, but the moment the inspiration reached such a point that the fingers felt the liver touch them through the abdominal wall her respiration became suddenly arrested as if she was caught in a vice, and she complained of feeling a pain as if she had been stabbed.

Mayo Robson's tender point was next looked for and found to be present—that is, a tender point situated about 1 to 1½ inches above and to the right of the umbilicus. It is elicited by pressure of one finger along a line drawn from the junction of the ninth rib with its cartilage to the umbilicus, and is analagous to McBurney's tender point in appendicitis.

A painful area was also found on pressure in the back about two inches to the right of her spine and situated opposite the 11th and 12th dorsal and 1st lumbar vertebral spine. She was troubled with constipation. The urine is clear and free from albumen, and she has never been jaundiced. The clinical features were those of gall-stones in a gall-bladder, associated with a chronic cholecystitis and in all probability adhesions. The gall-bladder was not palpable. The diagnosis made before operation was gall-stones, on account of the repeated attacks of biliary colic, and chronic inflammation of the gall-bladder on account of the tenderness on pressure below the right costal arch and the sudden arrest of the respiration on taking a deep inspiration while the fingers were being pressed deeply below the ribs. That the gall-bladder would probably be found sclerotic and contracted was assumed from the long history and the knowledge that this is the common pathological change that takes place in old-standing cases of gall-stones that are causing trouble. Adhesions were diagnosticated for the same reason, and on account of the dragging pain. At the operation, which was performed two days after admission, on opening the abdomen in the usual way through the outer third of the right rectus muscle we first encountered the right border of the great omentum adherent all round the area below the right lobe of the liver. The gall-bladder was not to be seen anywhere. A large sponge was placed well down in the right kidney pouch, and elsewhere around; as adhesions were gradually separated, sponges were placed with the object of diminishing any risk of infection of the rest of the peritoneal cavity. On separating the omentum, the hepatic flexure of the colon and the duodenum (first stage) were found adherent to the under aspect of the liver, and what subsequently turned out to be the gall-bladder. With some difficulty the intestines were separated, and the gall-bladder freely exposed and found to contain calculi. After palpating the bile ducts, the gall-bladder was pulled forward and opened. Four fair-sized calculi were removed, but the finger inside could still detect calculi which seemed to be separated from the finger by a small amount of tissue. It was thought these might possibly be lying in a diverticulum of the gall-bladder, and as this viscus seemed but a useless appendage, it was decided to remove it. As it was being separated from the under surface of the liver, an abscess cavity was opened in the liver from which nine large-sized calculi were extracted. These had probably ulcerated from the gall-bladder into this position. The gall-bladder having been removed, and the abscess cavity cleaned out, the ducts were once more examined, and found free. A tube was then placed in contact with the cystic duct and fastened thereto by a single fine catgut suture. A small piece of gauze was packed loosely around it and into the cavity in the liver, and the rest of the abdominal wound closed by sutures. The patient, as you can see, has made an uninterrupted and rapid recovery.

With regard to the etiology of biliary calculi, I will merely state that bacterial invasion in a more or less attenuated form seems to play the most important part in leading to the production of gall-stones. The organisms gain entrance either through the common bile duct from the intestines, or through the portal vein. Much has recently been written in connection with this latter channel as the path of infection, and much experimental work in this direction has been done. Inflammatory or ulcerative lesions of the intestinal tract, in opening up a path for the entrance of organisms, is probably of great importance. This may explain the frequency with which gall-stone troubles are met with in patients subsequent to attacks of enteric fever. During recent years, too, attention has been drawn to the association of appendicitis and gall-stones. Lesions of the appendix would doubtless open up the path for infection of the blood in the portal system. Gall-stones are met with about four times more frequently in women than in men. The condition is much commoner after 45 years of age, but calculi which form at an advanced period of life do not produce

symptoms with such frequency as when they form before 50 years of age. Gall-stones are composed chiefly of cholesterin, with a variable amount of bile pigments and calcium salts. There may be only one calculus or there may be thousands, and their size varies inversely with their number. Multiple calculi are always facetted, and they almost always form in the gall-bladder. The pathological changes induced by gall-stones are many and diverse. I will enumerate only those most frequently seen, and pass over those of greater rarity.

Cholecystitis or inflammation of the gall-bladder is the most common. It varies in severity from what may be termed slight evidences of catarrh of the lining membrane to the most virulent types of acute phlegmonous inflammation ending in gangrene of the entire viscus. Such a condition generally gives rise to a rapidly spreading acute septic peritonitis. Repeated attacks of a milder type of inflammation spreading through all the coats of the gall-bladder ultimately lead to sclerosis and shrinkage, while adhesions are almost certain to be met with binding the pylorus, duodenum, colon, or great omentum to it more or less firmly, thus leading to a variety of complications, such as dilatation of the stomach and intestinal obstruction.

Sometimes calculi lead to ulceration of the gall-bladder and find their way into a mass of adhesions producing a localised abscess; or perhaps they ulcerate through the wall of an adherent piece of intestine, and thus escape, to produce intestinal obstruction, or perhaps to pass out without causing further trouble. (Nature's attempt to cure). In the case of the patient before us ulceration took place into the liver, producing abscess therein. A gall-stone may pass into the cystic duct and lodge there, thus producing distension of the gall-bladder with mucus — the so-called hydrops vesicæ fellæ—provided the gall-bladder is capable of distension.

Infection following upon such a condition produces empyema of the gall-bladder, or distension of the gall-bladder with pus. A stone which was impacted in the cystic duct, even after its passage or removal, may later lead to hydrops through the cicatrisation of an ulcer produced by its pressure. Gall-stones not infrequently pass on into the common duct and produce a temporary obstructive jaundice, or may become lodged therein more permanently, and thus produce chronic obstructive jaundice. Such a condition as the lodgment of a stone in the common duct is invariably attended by, or associated with, the development of an infective inflammation of the ducts right up into the liver substance—infective cholangitis—which may induce abscess in the liver, or more general suppurative hepatitis. A calculus may become impacted in any part of the common duct, including the ampulla. A stone lodged in this latter situation may be followed by the development of inflammation of the pancreas, which may be either acute or chronic. This by no means completes the list of pathological phenomena which may be met with, yet I would be failing in my obligations to you were I to omit to draw your attention to the association between cancer of the gall-bladder and biliary calculi. Cancer of the gall-bladder is seldom if ever met with unless associated with, and in all probability subsequent to, the development or formation of gall-stones in that viscus. In concluding my remarks on the pathological changes induced by cholelithiasis, let me say that calculi induce changes in the liver itself, such as cirrhosis and the development of an important, though by no means invariable change that is commonly associated with the presence of calculi in the gall-bladder, viz., the formation of Riedel's lobe—a tongue-shaped process which projects downwards from the right lobe. Riedel puts forth the opinion that the gall-bladder in its enlargement gradually drags downwards this tongue-shaped process. Moynahan, however, mentions having seen the condition well marked in the absence of gall-stones when operating for other abdominal conditions.

Now, with respect to symptoms and signs, I may say at the outset that gall-stones may exist for years in a gall-bladder and yet may not produce any symptoms or signs by which their presence can be detected. This simply means that inflammation of an acute or sub-acute type has not been induced in the gall-bladder. It is stated, however, that if a large number of patients be taken who complain of gastric trouble or discomfort vaguely described as "indigestion," in by far the larger majority gall-stones will be found in the gall-bladder. "Indigestion," therefore, is generally mentioned as the most common symptom of gall-stone disease. When gall-stones produce evidence of their presence, this evidence must be as varied as the pathological changes they may induce, but it is obvious they lead to recognition in one of two ways.

First by causing irritation, thus facilitating infection and inflammation, and secondly by passing along the ducts either cystic or common and in their passage exciting muscular spasm or becoming impacted in either of these ducts. The phenomena thus produced consist of some or all of the following features:—

(1) Pain, which may be localised, referred, or typical biliary colic. The localised pain is generally felt over the gall-bladder area, and may be either dull, aching, or sharp and severe and dependent upon distension or inflammation therein. The referred pain is most commonly described as being felt in the back of the right shoulder—the inferior angle of the right scapula; but it may be referred to the front of the chest. Sometimes it radiates from the epigastric region round the entire right side. The typical colicky pain is characterised by the suddenness of its onset, by its intensity, and by the abruptness with which it ceases. This colic is, therefore, in all probability due to the irritation and spasm excited by the passage of the stone along the ducts, and it lasts just so long as the stone is moving along. In all probability it is indicative of a violent effort on the part of the unstriped muscle in the wall of the duct to overcome the obstruction produced by the stone and drive it out.

(2) Nausea, retching and vomiting are, apart from the so-called "indigestion" the commonest features of gall-stone trouble, and are probably reflex in their origin. The severity and persistence of the vomiting have been known to lead to the death of the patient.

(3) Jaundice is not by any means so common a feature of gall-stone trouble as those mentioned. It is doubtful whether it will be met with in even 40 per cent of the cases. When present, it indicates either impaction of a stone in the common or hepatic duct, or infection and inflammation of these ducts. It has been occasionally found to be due to the pressure on the common duct of a large stone lodged in the cystic duct. In these cases the urine contains bile pigments, while the fæces for the time being become light-coloured.

(4) Fever is a common accompaniment. It is characterised by the rapidity of its rise and the suddenness of its fall. Moynahan has very aptly described the chart as the "steeple" chart of gall-stone trouble, and he considers this type of fever pathognomonic of gall-stone disease. Murphy, of Chicago, also speaks of these rapid variations of temperature as characteristic and calls the condition the "temperature angle of cholangeic infection."

(5) Tumour is due to distension of the gall-bladder. It may be due to an acute obstruction of the common duct in an early case, but is most frequently due to blocking of the cystic duct by a stone, or some other condition leading to its occlusion. In the large majority—75 to 80 per cent.—of old-standing cases of cholelithiasis the gall-bladder is either bound down by adhesions to such an extent that it cannot distend or its walls have become thickened and sclerotic from repeated attacks of inflammation and it exists only as an atrophic, useless and possibly dangerous appendage which is incapable of being distended so as to produce a palpable tumour.

Time will not permit me to go into the special features of gall-stone disease, for that would mean going into the manifestations of all the various pathological changes previously mentioned. I will merely mention that stones in the gall-bladder are recognised chiefly

by the evidences of cholecystitis—pain, localised and referred, tenderness on pressure over the gall-bladder, possibly muscular rigidity of the right rectus in its upper third, and Mayo Robson's tender point.

A stone in the cystic duct causes severe biliary colic, pain due to distension of the gall-bladder, which may be palpable and produce tumour, nausea, and vomiting without jaundice.

A stone in the common or hepatic duct causes severe colic, nausea, vomiting, jaundice with pigmented urine and light-coloured stools, and spiky temperature, with shivering fits and sweating.

A stone in the common duct may lead to chronic obstructive jaundice, which may last for months or years, and which must be carefully distinguished from another common cause of chronic obstructive jaundice, viz., cancer of the head of the pancreas.

In the chronic choledochus obstruction arising from stone, the history dates back for a long period—months or years—and is characteristic of cholelithiasis; there are repeated attacks of biliary colic with nausea and vomiting, and the jaundice develops suddenly after such an attack, is very remittent, and varies in its intensity from day to day, or week to week, being well-marked immediately after an attack of pain and vomiting and then gradually becoming less marked until it appears only as a sallowness of the skin, to reappear in intensity after another attack of pain. The urine and fæces likewise vary. When the jaundice is increasing in intensity after an attack of pain, the urine becomes deeply pigmented and the fæces assume a light appearance, but in a couple of days the jaundice begins to fade, the urine becomes less deeply coloured until it may become almost normal again, while the fæces become brown or dark again. Rigors with sharp pyrexial attacks, followed by sweating, are common, and it is but seldom one can palpate the gall-bladder—in fact it is generally contracted.

In cancer of the head of the pancreas the history is short—a few weeks at most—the onset of the jaundice is painless and gradual, or if not quite painless, the pain is certainly not that of biliary colic. The jaundice once it appears varies only by becoming more intense from day to day and week to week until the skin assumes a yellowish green or greenish black appearance—a greenish tint in a jaundiced skin is very suggestive of cancer—the urine continues to get darker in colour from day to day until it becomes quite black like porter, while the fæces are quite light in appearance—a drab colour. There are no rigors or pyrexial attacks as a rule, and in the large majority of cases the gall-bladder is readily palpable as a pear-shaped tumour, and in thin subjects it may easily be seen projecting under the abdominal wall and passing down as far as, or even below, the umbilicus. Here I would impress upon you the importance of Courvoisier's law—"That in chronic obstructive jaundice due to blockage of the common duct a distended gall-bladder indicates that the cause of the obstruction is due to something other than stone, most likely cancer of the head of the pancreas, or possibly cancer of the duct itself or duodenum at the point of entrance of the common duct. If the gall-bladder is not distended (contracted) the cause of the obstruction is stone." This rule will be found to hold good in fully 90 per cent of cases.

The reason of this is obvious from what I stated in connection with the pathological changes calculi induce.

The points in the physical examination of the patient I have drawn your attention to in reading the history of this case.

The diagnosis in typical cases is easy, but in other cases the best one can do is to make a presumptive diagnosis, or perhaps an alternative diagnosis. The conditions most likely to be confounded are ulcers of the pylorus or duodenum, appendix trouble where the cæcum remains undescended, movable kidney and occasionally renal calculus. The latter two conditions are not so likely to cause confusion and difficulties in diagnosis as the former two, and the best that can be done at times is to make an alternative diagnosis.

Prognosis.—Once gall-stones have declared their presence, it is doubtful whether anything short of operative treatment can have any lasting effect. Rest, dieting, and the "Carlsbad cure" will subdue the inflammation and give relief, but, as long as the gall-stones remain in the gall-bladder, or ducts, cannot be expected to cure. The surgical treatment of gall-stones in a gall-bladder but slightly altered in structure consists in removal of the calculi and drainage of the gall-bladder by suturing the edges of the opening into it to the parietal peritoneum and posterior sheath of the rectus muscle—not to the superficial structures or skin—cholecystostomy. In other cases where the gall bladder is structurally much altered it is better practice to remove it. A fairly useful guide for the beginner to follow with a view to determining whether he should remove the gall-bladder or simply drain it is as follows: "Generally speaking, gall-bladders which at operation are found to contain bile may be drained, as, if bile can get into them, the mucus they secrete can get out." "Bladders which are suspiciously thick and hard should be removed." In this way very early cancers may be extirpated with every prospect of cure.

Gall-stones firmly impacted in the cystic duct may be removed by incision of the duct over the stone (cysticotomy) followed by drainage of the gall-bladder, or, a still better treatment is removal of the gall-bladder and portion of duct with the stone impacted *in situ*. If it is considered necessary to drain the hepatic ducts this can easily be accomplished by passing a tube through the opening in the cut cystic duct and running it up into the hepatic duct where it can be fixed by passing a fine catgut suture through the wall of the cystic duct and tube. Gall-stones impacted in any portion of the common duct except the ampulla are treated by choledocotomy, or, cutting down on the stone, extracting the calculus and subsequently draining the ducts by passing a rubber tube through the opening in the duct and running it up to the hepatic duct, and then fixing it by passing a single fine catgut suture through the wall of the duct and the tube. A small piece of gauze packing should be placed around the tube. The opening in the common duct may be closed by suture if desired, and the gall-bladder opened and drained, but drainage through the opening in the common duct is the more preferable procedure. Of course, if the gall-bladder is structurally much altered, it should be removed, when drainage can be employed through the cystic duct and the common duct sutured. A stone impacted in the ampulla must be removed by opening the second stage of the duodenum transversely through the anterior wall opposite the ampulla. The mucous membrane over the stone is then incised from within the duodenum and the calculus extracted. There is no occasion to suture the cut mucous membrane. The duodenal opening is closed with two rows of suture in the ordinary way. The rest of the ducts are explored and the gall-bladder opened and drained or, if necessary, removed and the ducts drained through the open cystic duct. Occasionally a stone impacted in the retroduodenal portion of the duct can only be extracted by incising the duodenum as above, and then cutting directly down upon the stone through the posterior duodenal wall and duct, which is closely applied thereto. After extracting the calculus it is usual to pass one or two catgut sutures through the incised duct and duodenal walls, after which the primary incision in the duodenum is carefully closed as before. This procedure is sometimes called Kocher's choledochoduodenostomy.

Let me state that I do not think at present any sane modern surgeon would extract calculi out of a gall-bladder, then suture up the opening, drop the viscus into the abdomen, and close the abdominal wound without drainage. Such a procedure courts disaster, and shows absolute ignorance of the great principle of gall-stone surgery, which is to remove not only the calculi but to get rid of the infection and thus arrest the inflammation which led to their production. This principle means "drainage."

A word in conclusion on the mortality of these different operative procedures.

The mortality at present of cholecystostomy in an otherwise uncomplicated case is, I feel sure, all round well under 1 per cent.; in fact, in the last series of over 450 cases of simple gall-stone disease in the clinic of the brothers Mayo, the mortality was less than half of one per cent.

In the operation of cholecystectomy for gall-stone disease as distinct from cancer the mortality is probably about 2·5 to 3 per cent.

The mortality attending the operation of choledocotomy rises considerably higher, and seems to vary in the hands of different surgeons whose experience is sufficiently large from which to draw conclusions from 2 per cent. in the quiescent period to 11.7 per cent. in acute cases. The mortality at the least is about five times as great as if the calculi were confined to the gall-bladder. The reason of this is that two serious elements are introduced in common duct surgery, viz., jaundice and infection, and the mortality both immediate and remote depends entirely, or almost so, upon these two factors. In very chronic cases, too, the function of the liver cells becomes so completely disorganised that even after the obstruction is removed and drainage instituted they never regain their power to functionate and secrete bile again, death taking place in a day or two, the ducts at operation in such cases contain nothing but mucus. The important deduction to draw from this statement of the mortality of these different procedures is to recognise the trouble while the calculi are still in the gall-bladder and have them removed with the minimum of risk.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week's issue will be by Francis Warner, M.D. F.R.C.P.Lond., F.R.C.S., Senior Physician to the London Hospital, "On Defects in Development: Their Significance," delivered at the London Hospital on October 31st, 1906.*

ORIGINAL PAPERS.

TWO CASES OF ŒSOPHAGEAL STRICTURE,

ONE MALIGNANT AND ONE CICATRICIAL,

TREATED BY GASTROSTOMY. (a)

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THE two cases presented in these notes were different in origin, degree, and urgency; and, when considered in contrast, their clinical histories were very typical of two of the main types of obstruction of the gullet. From the surgical point of view, the difference of age, and of the probable size of the stomach, raised the question of the most suitable operation. The element of time was an important consideration, since the older patient was weakened by age, disease, and limited alimentation, and the younger one was greatly emaciated by a long period of absolute starvation. The method adopted seemed most likely to suit both patients in the matter of speed and comparative freedom from shock, and, as the results show, it was well adapted for both.

CASE 1.—*Malignant Stricture.*—J. W., æt. 70, a joiner, sent by Dr. Stevenson, of Larkhall, consulted Dr. Monro on June 23rd, 1906, and was afterwards (July 2nd) admitted to his wards in the Royal Infirmary. The principal symptom was a difficulty in swallowing, which had come on gradually in the early part of the year, but had recently increased more quickly. At first there was trouble chiefly with butcher meat and fish, while other solids and liquids went down quite well. For about a month before admission a good many mouthfuls which the patient attempted to swallow were rejected, but he never had any trouble with liquids unless he had taken solids immediately before.

He never put up sour material or blood, or anything resembling coffee grounds. He had no feeling of sickness, and he felt that he could take more food if he could get it down. The stools were natural in appearance. He had no pain, but he felt as if there were an obstruction at the level of the fifth costal cartilage. He had lost two stones in weight since his illness began. There was nothing in the history to suggest that any corrosive substance had been swallowed.

A stomach tube passed on July 3rd met with some resistance soon after it entered the gullet, but this resistance was easily overcome. The end of the tube, on withdrawal, yielded a little blood, among which large squamous cells were found. There was no evidence of secondary disease in other accessible parts. The patient was transferred to Dr. M'Gregor's care on July 6th.

Operation.—On July 7th the following operation was performed under chloroform anæsthesia. The skin incision was made almost vertically through the left rectus abdominis muscle at the level of the distal ends of the eighth and ninth ribs. The incision was carried directly through the abdominal wall. The stomach was found empty, and there was no evidence of new growths in its wall, and no tumour could be felt at the cardiac end. An abnormal mass was found under the liver, probably a secondary glandular lesion. A cone of stomach was delivered through the abdominal wound by traction on a silk suture inserted just above the greater curvature towards its cardiac end. Traction on this suture was maintained until the base of the cone was sutured to the abdominal wall. An incision was then made in the apex of the cone of stomach sufficient to admit a No. 12 (E) catheter. A strong rubber catheter was inserted and sutured to the opening by a catgut suture. The apex of the cone was invaginated by pushing in the tube, and a continuous catgut suture was employed to fix the stomach wall to the tube during the process of invagination. When the stomach had been returned as far as the sutures fixing it to the abdominal wall, the deeper parts of the wound—muscle, sheath, and subcutaneous tissue—were sutured close up to the tube. The skin was fixed with Michel's clamps. A dressing was applied, and the tube was clamped outside the dressing.

The after history was uneventful. For the first few days the patient was fed every four hours by nutrient enemata consisting of 3 ozs. of peptonised milk. About 6 ozs. of saline solution were administered per rectum at intervals. After the first day he had sips of hot water by the mouth, and feeding by the tube was begun on the third day. The skin clamps were removed on the seventh day, and the tube on the thirteenth day. The wound looked well and was dry except for a slight amount of excoriation round the tube. Vaseline and sodium bicarbonate were then used as a dressing

On July 30th, 18 days after operation, it was noted that "the patient is now feeding himself by the tube, which he introduces each time." The patient's general condition was poor, and he was rather weak. He had, however, been out of bed for some days prior to dismissal.

After leaving hospital the patient reported himself at intervals, and expressed himself satisfied that he had gained in strength. On one occasion a dressing forceps was used to stretch the opening, which had contracted slightly at the level of the skin.

CASE 2.—*Cicatricial Stricture.*—Jessie W., æt. 21, a domestic servant, was admitted to Dr. Monro's wards in the Royal Infirmary on June 15th, 1906, having drunk a quantity of ammonia after a difference with her sweetheart. She was semi-comatose and her pulse was very feeble. The skin was peeling from the lips

(a) The patients were shown at a meeting of the Glasgow Medico-Chirurgical Society, on November 16th, 1906.

and the mucous membrane from the interior of the mouth, while the tongue was bleeding. There was a good deal of albumen in the urine. She could scarcely swallow anything Three days later she was still complaining of much pain in the mouth, and along the front of the chest down to the stomach. Small sloughs were separating from the tongue. There was nothing noteworthy about the heart or lungs. She still vomited when she tried to drink anything. A week after admission she was still vomiting, though she was able to retain some milk. The vomitus included brown and green material. The maximum temperature observed was 99.8° F. on the day after admission. She was dismissed on July 3rd, to all appearance quite well.

Very soon, however, she became unable to swallow, and she was re-admitted on July 23rd. Any fluid which she tried to take was rejected in about a minute. She felt as if the obstruction were situated about an inch above the xiphoid. She also complained of weakness. On July 25th the œsophagus was examined with bougies. A moderately thick one was arrested soon after it entered the gullet. A medium-sized and a fine one were both arrested at about 10½ inches from the incisor teeth. She was transferred to the surgical wards under Dr. M'Gregor's care on the following day.

On admission to the surgical wards her temperature was 98.4° F., the pulse rate was 64, and the respirations averaged 16 per minute. The cheeks were flushed and well filled out. The eyes were clear, the pupils medium and active. The tongue was moist and slightly coated at the back. The muscles were all flaccid, but emaciation of the arms and legs was not extreme. The body was very thin, and this condition was most markedly seen on inspection of the abdomen, where the thin abdominal wall seemed to fall away from the ribs, and the iliac crests stood out with undue prominence. The eyes were deeply sunken in the orbits. The heart and lungs were normal. The urine was loaded with urates (amorphous urates and urate of soda). Neither albumen nor sugar was detected.

Operation.—Gastrostomy was performed by Dr. M'Gregor by the method already described.

Nutrient enemata were administered shortly after the operation, and were continued, with saline rectal injections at intervals, till August 1st. Alimentation by the tube was begun on the day after the operation. The patient had been troubled with nausea, flatulence, and retching, and at night morphine was given hypodermically. The Michel's clamps were removed on the fifth day, when the wound was found quite dry. From that date the patient made steady progress. The amount of fluid nourishment taken by the tube amounted to between three and four pints per diem. The tube was found loose at the next dressing, on the tenth day, and there were no signs of irritation about the wound. On that date, August 11th, an attempt was made to pass œsophageal bougies, but without success. On the following day she swallowed 10 ozs. of milk, and also some rice and milk. This was the first thing swallowed by the mouth for over a month. She continued to make progress, though slowly, in the restoration of her general health. No difficulty was experienced in the administration of food, though the quantity taken at each time was small. For about five weeks after the operation her mental condition was one of depression, with lack of interest in her own recovery, but in the early days of September she became brighter, and began to take an interest in the work of the ward, and in her own condition. On the 19th of that month she was transferred to Dr. John Macintyre's care for direct treatment of the œsophageal constriction. See Dr. Macintyre's note.

The operation in this case was very easily accomplished, though it should be remarked that the diminutive size of the stomach allowed but little choice in the selection of a suitable point for the opening An attempt was made to pass a No. 1 œsophageal bougie from the stomach to the gullet without success, and, as the patient's condition was somewhat critical, it was not deemed advisable to prolong the operation. The amount of retching and discomfort after the operation was probably due to tension resulting from the small size of the stomach, and indicates that other operations requiring a larger amount of stomach wall would have been followed by greater discomfort and perhaps lack of success.

Note by Dr. John Macintyre.—The patient was first seen in the throat wards on September 9th. A careful examination showed that no food could be passed into the stomach through the mouth. There was a great accumulation of œsophageal and buccal mucus, causing the most distressing symptoms. A small oval Mackenzie bougie could be passed to the seat of stricture, but no further. With a view to localising the upper part of the obstruction, a metal coin-catcher was passed down, and an X-ray photograph taken. This showed that the instrument was arrested at the level of the fifth dorsal vertebra.

On the 14th of the month I succeeded in passing a No. 1 Mackenzie oval bougie. On the next day the same instrument, when passed, set up irritation of the stomach, and, for the first time, the patient ejected fluids clearly coming from the stomach. Day by day the conditions were carefully observed, and as often as possible an instrument was passed into the stomach. Now and again it was necessary, however, to stop the treatment, because the slightest extra irritation caused spasm, so that at no time force was used.

For a week previous to dismissal on September 27th, it was quite evident that fluids could be swallowed; so that, within three weeks, one could say that there was distinct evidence of fluids being passed upwards from the stomach, and fluid food in small quantities downwards into the stomach. This process of gradual dilatation has been continued; but, as before, at intervals, the process has been stopped whenever there was any evidence of irritation or of extra sensitiveness.

The question of how far the process will ultimately be successful cannot at present be answered. When the mucous membrane of the œsophagus is thoroughly cleansed, and Killian's instrument for direct illumination of that organ is passed, it is seen that the mucous membrane above the seat of the stricture is fairly healthy. The cicatricial portion seems pretty well limited to a short length of gullet below the level of the fifth dorsal vertebra, because, as soon as the seat of obstruction is passed, the bougie enters freely into the stomach. At the present time the largest-sized instrument passed has been a No. 3.

The case presents many points of interest, and not the least difficult part of the treatment is caused by the present state of the stomach. Dr. M'Gregor states that at the time of operation the viscus was very much smaller than normal, and this perhaps explains, to a certain extent, the very frequent attempts at retching and vomiting with which we have become familiar since the œsophagus was opened. On one occasion castor oil, which was passed into the stomach through the new opening, and not by the mouth, was immediately ejected through the œsophagus, and, with it, bile and some liquid food which had been taken shortly before.

The process of gradual dilatation is the one which I have selected in this case, in the first place because, in similar cases in my experience, if often proves successful, and in the present sensitive condition of the œsophagus and stomach of this patient any attempt at passing a tube into the œsophagus and leaving it there would set up irritation. Whether or not it will be possible, in the future progress of the case, to pass and leave in a Symond's or other tube, cannot at present be stated, but it is to be hoped that by careful and persistent, gradual, if slow, dilatation of the œsophagus, the natural channel may further be opened up.

Remarks by Dr. M'Gregor.—The operations were almost identical in these two cases, and, for the most part, the indications given by Binnie (*Oper. Surgery*, 2nd Ed., p. 245), under the title "Stamm-Kader," were followed. The procedure is one which seems to have been evolved from the combination of more than one of the cone methods of treating the stomach, and, in addition to those mentioned, the method of Senn seems to have been a progenitor. A departure from the method as described by Binnie was made in one or

two matters of detail. The stomach was fixed in the wound by sutures at each end, which included the peritoneum and deep fascia of both sides. After these were tied, a row of continuous catgut sutures was used to fix the base of the cone of stomach to the peritoneum and deep fascia on each side of the wound. The point of the tube was next fitted into an opening in the apex of the cone, and fixed there with a continuous suture through stomach and tube. Another suture was used, spirally, to fix the remainder of the cone, during its invagination, to the tube. The stomach was infolded as far as the posterior wall of the sheath of the rectus muscle, and then the wound was closed by interrupted deep sutures right up to the tube, without the insertion of any local drain. Michel's *agraffes* were used for the skin suture.

For ease and speed of operation the above method is preferable to any of the better known methods, such as the Franck and the Witzel, or their modifications. The efficiency of the valve action in preventing leakage is excellent; the removal of the tube between meals, and its re-introduction by the patient, are easily accomplished; and the absence of a fixed tube is a great convenience. The amount of contraction after four months is small, and a No. 12 E catheter is easily passed. Recently, in another patient, a much larger tube was used, in the hope that a larger opening would be more serviceable to the patient.

TUBERCULAR ULCERATION OF THE TONGUE.

By ANDREW WYLIE, M.D., C.M.,
Assistant-Surgeon, Central Throat and Ear Hospital;
AND
WYATT WINGRAVE, M.D.,
Pathologist, Central Throat and Ear Hospital.

A. F., æt. 24, van driver, consulted me in August last, complaining of "loss of voice, great difficulty in swallowing, and pain in his tongue when eating solid food."

Patient stated that he was perfectly well until last Christmas; after that time his voice became gradually thick, rough, and hoarse. He coughed considerably at times.

About the middle of January a small "blister" appeared near the centre of his tongue, which became gradually larger until it was a deep hole. He consulted his own doctor in April, chiefly because of the pain both on swallowing and in his tongue when eating, who, in view of the ulceration of the tongue being the first and most prominent sign of disease, attributed it to syphilis, and prescribed potass. iodid. in large doses for fully three months, with no beneficial effect.

The patient gradually grew thinner, hoarser, and had more and more difficulty and pain in swallowing, as the ulceration by this time had become more pronounced.

Patient gave no specific or tubercular history. He is married, but has no children.

The man was feeble, thin, and emaciated, and when examined he could not speak above a whisper, and only swallowed with great difficulty and pain. He had a severe cough, with slight expectoration, a hectic flush, but no night sweats.

The tongue was deeply ulcerated about the middle of the dorsum. It was irregular in outline, deeply excavated with punched-out ragged edges, the floor being rough and mamillated; there was no pain in it except when irritated by food or drink.

The pharynx, tonsils, and palate were normal. The epiglottis was large and œdematous, with superficial ulceration at the edges. The arytenoid cartilages were pale and very much swollen, while the inter-arytenoid space was the seat of considerable infiltration. The vocal cords were red, œdematous and thickened. The lungs were solid at the apices, with numerous crepitant râles. The cervical glands, both superficial and deep, were enlarged. Tubercular bacilli were present in the sputum.

A considerable part of the epiglottis was removed by Barwell's punch forceps, which afforded much relief to the pain and difficulty in swallowing; for several weeks he felt considerably better, was able to swallow food with comfort, and even gained a little weight. The ulcer was touched several times with formalin 2 per cent., and seemed to be healthier, but, severe hæmoptysis taking place, the patient died about six weeks afterwards.

Dr. Wyatt Wingrave examined the sputum, scrapings of the ulcer and the epiglottis, which was excised, and reports as follows:

Fig. 1.—Tubercular Ulcer of Tongue.

Scrapings from the lingual ulcer exhibited tubercle bacilli, and the usual cell elements, together with large epithelioid cells characteristic of a tuberculous process.

The sputum also contained tubercle bacilli.

The epiglottis was deeply infected with tubercular deposit, containing giant cells and bacilli *in situ*. There was well-marked perichondritis and some ulceration extending to the surface of the mucous membrane.

Remarks by Dr. Wylie.

The tongue is not very often primarily the seat of tubercular disease. It is affected sometimes by bacilli from the sputum through some erosion. It may also be due to the breaking down of an interstitial tubercular nodule, as was probably the case in this instance. The usual character is a shallow, superficial ulceration with well-defined edges, "granulated" base, and no induration, situated on the side or top of the tongue, and does not cause much pain, except during eating, when it is acute. In this case the ulceration is deep, ragged, with indurated and uneven edges, and has an appearance like a typical syphilitic ulcer; but the presence of pulmonary and laryngeal phthisis and the bacteriological evidence left no doubt of its nature.

Fig. 2.

I report the case as being a somewhat abnormal tubercular ulceration of the tongue.

Remarks by Dr. Wingrave.

The case is of interest by reason of the striking similarity which the lingual ulcer bore to a tertiary

syphilitic lesion following breaking down of a deep gumma.

Early tubercle of the tongue is generally superficial with a mamillated base and edge occurring either at the side or tip of the oro-glossus; situations favourable to erosions from the teeth which facilitate bacillary infection. The lingual tonsil is rarely a primary seat of tubercle, being generally involved with the faucial tonsils and palate in disseminated tubercle of lungs and larynx.

The appended photograph (No. 2) illustrates an *early* (and probably primary) tubercular ulcer of the tongue, having many of the characters of a "primary" syphilitic sore. It was taken from a patient, æt. 48, who died subsequently from an accident and acute miliary tuberculosis, whose case I reported to the Pathological Society in 1893; microscopic sections of the ulcer show typical tuberculosis.

The photographs illustrate the two distinct types of tuberculous ulcer of the tongue, the early or superficial and the deep. Dr. Wylie's case belongs to the latter type, since it probably started as an interstitial or submucous tuberculoma. It further illustrates the important aid to diagnosis which an immediate examination of the scrapings affords.

THE MOUTH AS A FOCUS OF INFECTION.

By FREDERICK NORMAN, M.D., F.R.C.S.ENG., D.P.H.,

Surgeon to the Camberwell Dispensary.

IT has long been my conviction that the mouth is the hotbed of many pathogenic organisms which perform a by no means unimportant rôle in the production of certain general disease of hitherto unexplained origin, but the source of which can be traced to the oral cavity. These pathogenic mouth bacteria are so numerous and so diverse in character that it is impossible to identify them by a simple microscopic examination of the saliva. Cultures on agar-agar are not satisfactory, for many of them will not grow on this medium or are of such feeble vitality that they are soon ousted by the more proliferous saprophytes of the mouth. Gelatin is equally futile for the purposes of diagnosis, and inoculation into mice is the only reliable criterion. It is many years since Pasteur discovered in the human saliva a pathogenic micro-organism in the form of a figure of 8, and since then Miller, of Berlin, Fränkel, Gaglio and Di Mattei, Banti, Foa, and many others, have furnished contributions dealing with the toxic properties of the saliva.

When a few drops of salivary secretion are injected into the abdominal cavity of a mouse, death ensues in a few hours, or it may be in a few days, from acute peritonitis or blood-poisoning, or both. Injections with the blood, or peritoneal exudations of these animals produce the same results as injections with the original saliva. Of salivary organisms cultivated on artificial media more than a score have been isolated and identified. Amongst the most important are Fränkel's diplococcus of pneumonia (possibly identical with the organism originally described by Pasteur) the micrococcus pneumoniæ of Friedlander, and the bacillus bucallis muciferens and various varieties of bacilli sputum septicæmia. In addition to actinomyces and saccharomyces albicans (thrush fungus), the bacillus tussi convulsivæ and the bacillus bronchitidis putridæ are not infrequently detected. Many diseases may be traced to the action of the bacilli having their habitat in the mouth. I do not propose dwelling at any length on purely local diseases, but reference may be made to caries of the teeth, alveolar abscesses, and their complications, ostitis, osteomyelitis, periostitis, and necrosis of the jaw. It has been abundantly proved that "phossy" jaw, due to phosphorous poisoning, is tuberculous in origin, the immediate source of infection being tubercle bacilli, which find a gathering place in the saliva. The infectious anginæ such as tonsillitis, amygdalitis infectiosa, and their several complications are due to the localisation of germs and their entrance through the tonsils. Angina Ludovici, noma, stomatitis, and other similar conditions fall within the same category. Of other constitutional diseases with localisation in the mouth, diphtheria and syphilis serve as well-known examples.

The necessity for the adoption of antiseptic methods in all surgical operations is fully admitted, and is scrupulously enforced in all regions of the body with the solitary exception of the mouth and throat. No one seems to think of antiseptics in connection with tonsillotomy and uvulotomy, and that in spite of the fact, as has been shown, that the mouth is a receptacle for germs of all kinds, some benign and some pathogenic. It is true that in operations for the removal of the tongue for cancer, antiseptic precautions are observed, possibly from the fear of septic pneumonia, and it is safe to say that the mortality from this complication decreases in direct proportion to the strictness with which these measures are carried out. In these cases the patient is put through a preliminary course of dental treatment, all necrosed stumps being extracted and all decayed teeth carefully stopped. But still the main proposition maintains, and in the majority of operations in the region of the mouth and throat equal care is not observed. This carelessness is not readily capable of explanation, unless on the grounds that the methods by which oral sepsis can be ensured are not fully appreciated. The demand for the adoption by dental surgeons of the antiseptic measures observed in general surgery is becoming day by day more imperative.

The publication of Dr. Wyatt Wingrave's paper on "Oral Sepsis in Operations on the Throat" (*a*), forestalls to some extent certain clinical observations on which I have been engaged. My interest in the subject was excited by a consideration of the fact that we have few antiseptics in general use applicable to the disinfection of the oral cavity. The point we have to consider is what steps can be taken to prevent the growth of bacilli, pathogenic and non-pathogenic, in the mouth, with the view of limiting as far as possible the action of micro-organisms not only on the teeth and other organs of the mouth, but to keep in check those far more serious diseases which so frequently result from the want of attention to the mouth. There are many diseases of the mouth which readily take on a septic character, and although the list of mouth washes and gargles is comprehensive, there are none free from serious disadvantages. Carbolic acid and members of the phenol group are not only toxic in action, but when used over a long period exert a deleterious effect on the mucous membrane of the mouth producing in the epithelium and sub-epithelial tissues a carnification which is undoubtedly a step on the road to the precancerous stage. It is important to avoid injuring in any way the protoplasmic cells which by their function and activity resist the onset of malignant disease. Creosote, a crude mixture of guaiacol and creosol, is open to this objection. Corrosive sublimate is a violent tropical irritant producing cloudy protoplasm, so that it cannot be recommended for indiscriminate use, either in the form of a lozenge or a gargle. Permanganate of potassium is soon neutralised, and apart from its nauseous and sickly taste, has but little effect as a local antiseptic. It has the further disadvantage of staining the tissues with which it comes in contact. I have from time to time tried liquor carbonis detergens, creolin, and various other preparations, and have discarded them all in turn as being unsuited to my purpose. The essential oils, such as oil of peppermint, oil of cloves, and especially oil of cajeput, are useful intestinal antiseptics, but are unsuited for the disinfection of the mouth. Their persistent and pungent odour and taste induce a disrelish for food, and the patient soon complains of loss of appetite.

Formic aldehyde, a substance originally discovered by Hoffman, in 1869, is a more powerful disinfectant than carbolic acid, over which it has many advantages. Although destructive to micro-organisms, it is innoc-

(*a*) *Lancet*, October 20th, 1906.

uous to animals, and is practically non-toxic. From its pungent odour and taste it is by no means easy to prescribe it in a palatable form. Looking about for an efficient substitute, and one possessing equally powerful antiseptic and disinfectant properties, I tried Formamint, a definite crystalline body, a chemical combination of formic aldehyde, menthol and lactose. It is a penta-methynal lactose, having the chemical formula $5CHOH + C_{12}H_{22}O_{11}$. It is conveniently administered in the form of gramme tablets each containing 0.01 gramme of formic aldehyde. A fractional dose of citric acid is added which gives a sharp, pleasant, refreshing taste which is particularly acceptable to febrile patients, and is an advantage in the case of drugs intended to be swallowed slowly and to exert a topical action on the mouth and throat. A lozenge has many advantages over a gargle, not the least being that the mere act of sucking exerts reflexly a stimulating action both on the mucous membrane of the stomach and on the central nervous system. Mastication also increases the secretion of saliva, an abundant flow of which is necessary for preserving the sensitiveness of the nerve endings of taste. It is a somewhat curious circumstance, and one I have often noticed that children who are suckled enjoy an almost complete immunity from thrush, whilst those brought up by hand often fall victims to it.

I have used Formamint in a considerable number of diseases and morbid conditions of the mouth and tongue, of which a few only are here enumerated.

Pyorrhœa alveolaris, spongy gums, or Rigg's disease, is so common a complaint and usually runs so chronic a course that any means of alleviating the patient's suffering must prove acceptable. There is not only a spongy condition of the gums, but they recede, exposing a portion of the fangs of the teeth, which, no longer implanted firmly in their sockets, are loosened and not uncommonly drop out. The inflammation extends to the peridental membrane or periosteum of the fang, with the result that pockets of pus are formed which extend along the roots and involve destruction of the tissues of the gum and alveolus. It is said that this condition is due to the deposit of tartar from the saliva, but this explanation seems inadequate, and the disease is probably bacterial in origin, although no specific organism has yet been isolated. The difficulty arises from the presence of many varieties of micro-organisms in the mouth. I cannot help thinking that it is something more than a purely local disease, for its persistence is attended with far-reaching effects.

The constant drain even in small quantities of septic material into the stomach must be prejudicial to health. In the interest of the patient the condition should not be allowed to go on unchecked and uncured. For many years I used as a local application to the gums a mixture of equal parts of tincture of aconite and tincture of iodine, but this requires to be painted on not only frequently, but with care. Patients soon get careless about such matters, and neglect their teeth until they are so loose as to be in danger of falling out or so tender as to interfere with mastication. As a mouth wash I have used equal parts of tincture of cinchona and tincture of rhatany, but the bark is thrown down on the addition of water, and its astringency renders it anything but a popular remedy. Of late, and in a considerable number of cases, I have prescribed Formamint, and the result has been satisfactory. The constant action of an antiseptic which hardens and braces up the relaxed gums and adjacent mucous membrane gives just that amount of topical stimulant needed to restore the inflamed tissues to their normal condition. On the theory of a bacterial origin we have a ready explanation of the mode of action of the remedy.

Reverting to the subject of operations on the throat and adjacent parts, it is argued that as the mouth is the seat of much traffic, asepsis is impossible of accomplishment. That is an entire mistake, although I am prepared to admit that streptococcic infection rarely occurs. It is better to be on the safe side, and prior to an operation and after the last meal I make it a rule to direct the patient to allow one or more tablets to slowly dissolve in the mouth. Quite apart from other considerations, it occupies the mind during a period of mental anxiety and weary waiting. Wingrave points out that although it is impossible to sterilise the mouth and keep it sterile by the use of antiseptics, the risk of auto-infection during operations in its neighbourhood may be greatly reduced. It is especially in the case of anæmic and debilitated children that these precautionary measures should be observed, for it is in them that middle-ear infection follows adenoid operations.

Anæsthetic pneumonia occurs more frequently after the administration of ether than with chloroform, and in some cases may be due to the exposure of the patient to cold or possibly to the chilling effect of the anæsthetic. In more than one instance I have had reason to suspect a septic contamination of the mouthpiece of the apparatus. The risk may be small, but it is better to discount it by the use of a disinfectant, and for this purpose Formamint answers admirably. Moreover, it induces a condition of partial anæsthesia of the mucous membrane of the stomach and materially lessens the tendency to post-operative vomiting, whilst by its stimulating action on the nerve centres it wards off the effects of shock.

When patients are exposed to the contagion of such diseases as diphtheria and scarlet fever—I am almost inclined to include rheumatic fever in this category, seeing that it so frequently begins with an attack of tonsillitis—it is a wise precaution to ensure that the mouth and throat are in as an aseptic condition as possible. It is difficult to prove experimentally that this theory is sound, but there is much to be urged in its favour.

In acute tonsillitis I rely to a very large extent on the early administration of tincture of aconite in small and frequently repeated doses. As an adjuvant I use Formamint, and it certainly relieves the pain and feeling of tension in the throat. I note that Blumenthal, of Berlin, adopts the same method of local application, and that in a large number of cases, some of which he publishes in detail, he has obtained excellent results.

In cases of secondary syphilis treated with small doses of mercury, I give the patient careful directions respecting the necessity for ensuring the cleanliness of the mouth and teeth. Sometimes, however, in spite of all precautions, there may ensue ulceration of the mucous membrane of the mouth or of the tongue and tonsils. The custom is to order an astringent gargle, but, practically, a patient following his usual avocations cannot gargle when he is away from home. What is required is a continuous application—something that can be sucked in the tram or 'bus, in the office, or in the street. Lozenges of chlorate of potassium or of chlorate of potassium and borax are used for this purpose, but their antiseptic properties are slight. In Formamint the formic aldehyde is disengaged so slowly from the combination that although it exerts its disinfectant action topically the taste is covered by the menthol, whilst the citric acid braces up and stimulates the mucous membranes.

OPERATING THEATRES.

ROYAL FREE HOSPITAL.

REMOVAL OF GLANDS.—Mr. CUNNING operated on a case of recurrent carcinoma in the glands of the axilla and supra-clavicular glands in a female patient, æt. 52. A lump could be felt under the clavicular portion of the pectoralis major, the sternal portion having been removed at a first operation three years ago. Some glands could also be felt above the clavicle at the base of the posterior triangle. An incision was made extending from the left edge of the sternum to the insertion of the pectoralis major in the humerus at the level of the third intercostal space, and the skin was reflected from this both upwards and downwards.

The remaining portion of pectoralis major and the pectoralis minor muscles were then detached from their origins, and with their covering fascia, fat and an enlarged gland lying on the costo-co acoid membrane reflected outwards. The axillary vein was next exposed where it passes under the clavicle, and a careful dissection was made of the fat, and some infected glands which were surrounding this vessel. This was rendered very difficult by the fact that very dense scar tissue was present here as the result of the previous operation. The whole mass was now freed from the axillary vein and removed as one piece by detaching the insertion of the pectoralis minor from the coracoid process and the pectoralis major from the humerus. A second incision was then made at the level of the upper border of the clavicle from the inner edge of the sterno-mastoid to the insertion of the trapezius and another from the anterior end of this upwards for two inches along the anterior border of the sterno-mastoid. The sterno-mastoid was exposed and divided. A mass of glands was then exposed at the base of the posterior triangle reaching inwards to the internal jugular vein and running up along its outer side for an inch and a half. These were easily removed, and none could be felt running down towards the mediastinum. The incisions were then sutured and a small draining-tube left in each wound. Mr. Cunning called attention to the black pigment to be seen in the supra-clavicular glands. This, he said, was an unusual circumstance, and one rarely seen in recurrent carcinoma; he believed this coloration to be due to blood pigment. He also pointed out that although there were no traces of glands beyond those which had been removed, the prognosis must be grave in all cases where glands had to be removed above the clavicle. It was most likely that the mediastinal glands were also involved, though there was no evidence to that effect as yet. He considered that a perfect clearance could be obtained by this method of two incisions without dividing the clavicle. The gland on the costo-coracoid membrane was, he remarked, one which was frequently overlooked, as in a great number of cases it was never enlarged. Still, here was a case in which it was affected. This was an additional reason for taking away both pectoralis muscles so that the costo-coracoid membrane and its glands could be removed at the same time.

TRANSACTIONS OF SOCIETIES.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD DECEMBER 6TH, 1906.

Dr. J. O. AFFLICK, President, in the chair.

DR. W. G. SYM and Mr. CAIRD showed a patient who for 13 years had suffered from proptosis of the left eye, due to intraorbital tumour. The vision was not impaired, though latterly the proptosis had attained such a degree that the eye was almost completely extruded from the orbit. The tumour had been operated on after Krönlein's method, by removing the outer wall of the orbital cavity. The result had been completely successful, inasmuch as the proptosis was cured, while full vision had been retained.

Dr. W. G. SYM showed a child after enucleation of both eyes for glioma. The patient was the second member of the family who had been thus affected.

Dr. BYROM BRAMWELL showed a case of fracture of the base of the skull, followed by paralysis of several cranial nerves. The patient was a pitman, æt. 21. On May 3rd he met with an accident, which rendered him insensible for 15 minutes, and was followed by hæmorrhage from the nose and ears, and thereafter by a discharge of watery fluid (presumably cerebrospinal) from the nose. He was completely blind in the right eye from injury to the right optic nerve, the pupil being insensible to light thrown into that eye, while the consensual reflex was retained. The eye was immovable in an outward direction from paralysis of the right external rectus. The facial nerve was also paralysed, and three months after the injury there was reaction of degeneration in the affected muscles. There was also paralysis of the left external rectus. The object of bringing the case before the society was to show that notwithstanding the complete facial paralysis with reaction of degeneration three months after the injury, a few months later complete recovery had occurred. There was now practically no facial paralysis; the blindness, however, was permanent. A case like this showed that some time should be allowed to elapse before surgical intervention in the way of nerve grafting was considered.

Mr. CAIRD showed (1) two patients after removal of nasopharyngeal fibrous polypi. The first case was a boy in whom the first symptoms showed themselves in February, 1905. In July of that year the polypus was visible in the back of the pharynx, and urgent respiratory difficulty had necessitated an emergency tracheotomy. As a preliminary to removing the tumour the common carotid was exposed, and a temporary ligature placed round it so that hæmorrhage could be controlled if need arose. The tumour was removed after excising the upper jaw, by which means free access was gained. It recurred some months afterwards, but was easily removed by opening up the old incision. It was a simple fibroma, and appeared to have grown from the body of the second cervical vertebra. The second case was a lad of 13, in whom access had been got to the tumour by splitting the palate. The same preliminary tracheotomy and ligature of the common carotid had been carried out in this case also. It was noteworthy that the removal of the upper jaw caused very little deformity.

(2) A patient with injury to the elbow and contraction of the flexor muscles of the forearm (Volkmann's ischæmic contracture). In this condition there was hæmorrhage into the muscles which resulted in a deformity simulating that caused by musculo-spiral paralysis. It generally followed injuries to the elbow joint, for which splints had been applied. In the case in question, however, the injury (a diastasis of the lower end of the humerus) had been healed without splints. The fingers were flexed, and the hand in the position of wrist-drop; the fingers could not be fully extended unless the wrist was fully flexed on the forearm. The condition was due to a contracture of the flexor muscles, and, to remedy it, it was proposed to split the tendons of the affected muscles.

(3) Specimens of nasopharyngeal polypi.

Dr. BYROM BRAMWELL read a paper on

"THE PRESENT POSITION OF THE TUBERCULOSIS QUESTION IN SCOTLAND, WITH SPECIAL REFERENCE TO THE RECENT 'CIRCULAR' OF THE LOCAL GOVERNMENT BOARD."

The speaker first referred to the economic importance of fighting a disease which destroyed so many lives at the period at which the wage-earning capacity was at its maximum. Financially, therefore, the crusade against phthisis was justifiable. During the 30 years 1871 to 1901 the mortality had diminished in Scotland from 278 per 1,000,000 to 153 per 1,000,000, but none the less there was still great necessity for a combined effort on the part of the public, the medical profession, and the public authorities, in order to deal effectively with the disease. The fall in the phthisis death-rate had occurred in all parts of Scotland, except the insular rural districts. It must also be noted that in these districts the number of uncertified deaths was excessively high, so that probably the mortality from phthisis was even greater than appeared. The persistence of a high mortality in these districts was due to the bad sanitary conditions prevailing, as had been shown in Professor Dittmar's report on the Lews. The lessened death-rate elsewhere was due to better sanitation and conditions

of life rather than to any special steps which had been taken. In connection with the crusade against phthisis in Scotland, he alluded especially to Dr. R. W. Philip's work. By far the most important step taken in recent years was the issue by the Local Government Board of the Circular of March 10th, 1906, in which it was laid down that phthisis was an infectious disease, and therefore came under the provisions of the Public Health (Scotland) Act. In regard to phthisis, there had been a great advance in public opinion within the last ten, and particularly during the last five years. On the discovery of the tubercle bacillus, the disease was recognised as being infectious, but for a long time this had led to no practical result. Recently there had been a considerable change of opinion as to the propriety of the compulsory notification of phthisis. In 1898 Dr. Thorne Thorne had delivered a series of lectures on the administrative control of phthisis, and after discussing the pros and cons of compulsory notification, had declared himself against it. His strong adverse opinion had stopped all progress in that direction for many years. Shortly after Dr. Thorne Thorne's lectures had been delivered, Dr. Byrom Bramwell had discussed the subject in an address to the Fifeshire Branch of the British Medical Association, and had tried to prove that the arguments of the former were not valid. At that time, however, he met with little support. Seven years later the Fife Branch adopted a unanimous resolution in favour of compulsory notification. Last summer Glasgow adopted the practice, and he hoped it would soon become universal throughout Scotland. Coming now to the circular of the Scottish Local Government Board, which, as he said, he welcomed as the most important step in the administrative control of phthisis yet taken in the country, he thought that it was open to criticism in that it did not sufficiently emphasise the differences between the infectivity of phthisis and the infectivity of such other diseases as scarlatina, &c. In phthisis infection took place through the sputum only, and therefore could be controlled by disinfecting the sputum. In order to effect this administratively, compulsory notification was essential. Hitherto the attention of public health authorities had been limited to measures of general sanitation; now the great aim should be to disinfect the sputum, and he wished to emphasise the point that if this was efficently done the risk of infection of healthy persons was comparatively trivial. There was therefore no need for isolation. For this reason Clauses 59 (public conveyance clause) and 57 (school clause) of the Public Health (Scotland) Act, 1897, were far too drastic as applied to phthisis; these clauses should therefore be amended by a special Act. All that seemed necessary was to insert into these clauses the same *qualification* which is inserted into Clause 56, viz., "*wilfully* exposes himself *without proper precautions*." The legal question might arise at present whether a person suffering from phthisis, who destroys or disinfects his sputum (in other words, renders the infectious disease, phthisis, in his particular case, non-infective) could be convicted and fined under Clause 59. Dr. Bramwell argued that to extend these clauses to the special infection of phthisis was an unnecessary and harsh action, and that to do so would so alarm the public as to delay the coming of compulsory notification. The Hotel Clause (51) was also open to the same objection. Another point in which the circular of the Local Government Board was somewhat unfortunately worded was in the paragraphs relating to compulsory notification. These were to the effect that the Board was only prepared to consider favourably any application by a local authority to schedule phthisis among the compulsorily notifiable diseases if they were satisfied that the local authority was prepared to take steps to combat the disease effectively. Compulsory notification, *per se*, has, the Board stated, no administrative value. Dr. Bramwell pointed out that the compulsory notification Act was quite distinct from the Public Health Act, and that notification neither increased nor decreased the responsibility of the local authority under the latter Act. The speaker, however, understood that the wording of the paragraph in question did not accurately convey the intention of the Board. Notification was, of course, essential as a preliminary to taking any further steps. The Board had not intended to insist on the creation of curative sanatoria. They rather suggested the advisability of local authorities combining for the purpose of erecting such and equipping them specially for the treatment required. Dr. Bramwell concluded his address by again expressing his opinion that the clauses referred to are too drastic to be applied to phthisis, and require to be amended.

The paper gave rise to an animated discussion.

Dr. R. W. PHILIP said it was unnecessary to reiterate views which he had frequently taken occasion to express as to the great significance of the circular of the Local Government Board. There could be no doubt that the circular represented the highwater mark of official statement throughout the world on the subject of pulmonary tuberculosis. The authoritative declaration on the part of the Board that pulmonary tuberculosis was an infectious disease within the meaning of the Public Health (Scotland) Act, 1897, marked a great forward advance. On that account he would have been glad if Dr. Bramwell had prefaced his proposed motion with an expression of the Society's cordial approval—or, if it seemed more acceptable to the members, the Society's general approval—of the circular. It was a matter of congratulation for Scotland that a problem of considerable obscurity and difficulty had been cleared up by the issue of a statement at once definite and authoritative.

Dr. LAWSON (Banchory) spoke strongly in favour of compulsory notification. He alluded to the fact that the sputum of a patient might on one occasion be swarming with bacilli, and the next day be free from them. It had been proved that even when the organism was absent from the sputum, gelatine plates could be infected by coughing. He therefore considered that there was an element of risk even when the sputum was disinfected, and did not consider the provisions of the act too stringent.

Dr. NASMYTH (Fife) said the difficulty Dr. Bramwell alluded to has been a source of anxiety to him; but an explanation by the Local Government Board that it was not imperative to enforce the clauses harshly had relieved him.

Dr. DOUGLAS (Cupar) criticised the circular, in that it did not allow compulsory notification unless the local authority was prepared to deal further with the disease. Speaking as a medical officer of health, he said he could do nothing to prevent, say, a tuberculous dairyman selling milk, unless he had legal proof that he was phthisical, and this proof could only be furnished by compulsory notification. Without compulsory notification, he argued, no steps could be taken.

Dr. MATHESON CULLEN (Convener of Edinburgh Public Health Committee) thought that the clauses in question constituted no real danger. They were only carried into effect on the initiative of the medical officer of health, and comparatively few convictions had been obtained under them in regard to any infectious disease. They were only put into operation in flagrant cases, and he thought that they might safely trust to the discretion of the medical officer of health that they would not bear harshly on tuberculous patients; while, on the other hand, it was not a bad thing to have something of the kind to fall back upon.

Dr. NORMAN WALKER said he supposed that the way of dealing with the tuberculous would resemble that adopted in the case of leprosy in Norway—patients who took precautions were not isolated; those who refused to do what was right, or were unable to do so, were segregated.

Dr. BRAMWELL, in his reply, stated that he quite agreed that it was not the duty of the public authorities to cure, but to prevent disease. While, therefore, isolation hospitals for advanced cases were justifiable and necessary, the propriety of erecting curative sanatoria at the public expense remained an open question.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF PATHOLOGY.

President: J. F. O'CARROLL, M.D., F.R.C.P.I. Sectional Secretary: PROFESSOR WHITE, R.C.S.I.

MEETING HELD FRIDAY, NOVEMBER 23RD, 1906.
The PRESIDENT in the Chair.

PATHOLOGICAL EFFECTS OF RONTGEN RAYS ON ANIMAL TISSUES.

DR. HARVEY reviewed the main steps in the investigation of Röntgen effects since the discovery of the rays in December, 1895. He described Holzknecht's pastilles as the first attempt to measure the quantity of radiations employed, and showed how their employment led to definite laws concerning skin reactions. Passing on to the mode of action of the rays he mentioned Scholtz's view that epithelium is primarily affected, and those of Baermann and Linser and Gassmann, who hold that the effect is chiefly upon the vessels, and detailed the chief experiments of these authors. As to the actual agent causing dermatitis, the author held the Röntgen-rays themselves responsible, and favoured the trophoneurotic theory, and mentioned some original experiments on the effect of vasomotor disturbance on the phenomena. He quoted the experiments of Perthes, Dalous, and Lasserre as favouring a definite selective absorption. Coming to internal organs, he mentioned Heineke's experiments on the spleen, and those of Aubertin and Beaujard on the blood cells. With regard to the question of a Röntgen leucotoxin, he related the findings of Helber and Linser, and Curschmann and Gaupp on the one hand, and those of Kleineberg and Zoeppritz on the other. Lepine and Boulard's experiments on metabolism of glycogen were also mentioned. Albers Schönberg's classical experiments on the generative organs were recounted, as were those of Halberstaedter and others. Having mentioned some clinical features of X-ray treatment of pathological interest, Dr. Harvey spoke of his own experiments, showing microscopic and lantern preparations. The animals operated on were rabbits and guinea pigs, and the organs chiefly examined were the spleen, ovaries, testicles, and suprarenals. The experiments, which are in a preliminary stage, so far support Heineke's results in regard to the spleen. The germ centres of the Malpighian corpuscles were observed to be the first to suffer. Chromolysis and diffuse nuclear staining are present in most of the sections, and affect chiefly the young and proliferating cells. Vaso-dilatation and congestion are also common. The ovarian and testicular changes were similar to those described by previous authors. Dr. Harvey found congestion and hæmorrhages in the suprarenals of all animals subjected to X-ray treatment.

Dr. STEVENSON mentioned vesication as occurring in lupus in an area of the skin which had previously been exposed to the Finsen light. The application of the X-rays had made the skin react at that particular part, while there was no vesication or marked reaction in the surrounding parts.

Dr. WALTER SMITH considered the paper of great general interest from the point of view that such pathological observations bridged over the interval between normal physiology and therapeutics which might be called applied physiology. Broadly speaking, they might regard the action of Röntgen-rays and the like as an act of stimulation; but they need not attempt to distinguish too narrowly between the phenomena of excitation and depression, since they were but quantitative opposites which followed from continued application of the same stimulus. The nature of the Röntgen-rays had long been a puzzle to physicists. Now, however, it was agreed that they represented ethereal pulsations, and did not correspond in any way to a molecular bombardment. In discussing the physiological or pathological action of the rays, he thought it was impossible to form any satisfactory conception, unless they also took into consideration other therapeutic agencies with which they were familiar, such as the Finsen rays or radium. It was, he thought, rather unfortunate for students that the word "ray" had acquired two different significations. It retained its old meaning of undulatory vibrations of the ether, and was also applied to a direct stream of particles like the hail of tiny projectiles from radium. To get at a satisfactory explanation of the phenomena would require a thorough knowledge of the effects of all sorts of vibrations of different wave lengths, not only on animal, but on vegetable, tissues, distinguishing between the action on the higher and lower forms of vegetable life. The first indication of the therapeutic value of the rays arose, about 1900, out of the observation of their depilatory effect; it was premature to expect a coherent or fully satisfactory statement at the present time.

Dr. C. M. BENSON said that he had been handed over patients who had been treated for lupus by the Finsen light, and in his experience there had been no formation of vesicles.

Dr. SCOTT congratulated the Section on Dr. Harvey's contribution, which fixed certain points from which they could advance further. They knew certain tissues on which the rays acted; they might act on others; but that they should act on tissues of such a peculiar nature as the spleen and on the growing cells of epithelium would suggest that possibly growing cells were affected by the rays as they were by differences of acidity and alkalinity.

Dr. KIRKPATRICK thought they were perhaps frightened by the bugbear of permanent baldness in using the rays. He knew of a case of a woman in which depilation was produced, and after some months the hair grew more vigorously on her face than before the treatment.

Dr. HARVEY, in reply, said he had read of the X-rays being considered a cause of abortion. It would seem possible that they should have such an effect, as they seemed to show a greater effect on young and actively developing cells than on adult ones. His explanation as to what caused the death of the guinea-pigs in his experiments was that the X-rays caused a degeneration of cells, whereby a toxic product was liberated which killed the animals. The toxic effects of the rays had been observed in several cases, and he was in the habit of seeing that patients undergoing the treatment for malignant disease should take aperient medicine. The epithelium of the skin was not at all as sensitive to the action of the rays as that of the testicles or ovaries or spleen.

OTOLOGICAL SOCIETY OF THE UNITED KINGDOM.

MEETING HELD ON MONDAY, DECEMBER 3RD.

THE following were elected as Officers and Members of Council for the ensuing Session, 1906-1907. President: Alphonso Elkin Cumberbatch. Vice-Presidents: Arthur Henry Cheatle, John Middlemass Hunt, Adam Brown Kelly, Richard Lake. Honorary Treasurer: Edward Law. Honorary Editor of Transactions: Walter Jobson Horne. Honorary Librarian: Laurence Asher Lawrence. Council: Frederick William Bennett, Charles Herbert Fagge, Joseph Nelson, William Permewan, Hunter Finlay Tod. Honorary Secretaries: Henry Secker Walker, Ernest Blechynden Waggett.

At the Annual Dinner held on the evening of the same day the President, Mr. A. E. Cumberbatch, occupied the chair. After the usual loyal toasts Dr. Frederick Roberts proposed "The Otological Society," coupled with the name of the President, who responded. Mr. Cresswell Baber proposed "The Guests." The toast was responded to by Sir James Reid.

DR. LAPPONI, the Pope's physician, died on the 6th inst., at the early age of 54. For over 15 years he had acted as Papal medical adviser, most of the time to Pope Leo XIII. For some time past he has suffered from cancer of the stomach.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD

FRANCE.

Paris, Dec 9th, 1906.

UMBILICAL HERNIA IN INFANTS.

INFANTILE umbi ical hernia is in general benign and has a tendency to get well s ontaneously, or, at least, without surgical interference. It seems, however, to be more f equent in premature children, according to Professor Broca, and for this reason the umbilicus should be particularly seen to after the cord is detached.

Generally speaking, the hernia appears a few days after birth, a bandage is prescribed, and in a few months the hernia disappears.

But it happens sometimes that matters are a little more complicated, and then the prognosis is not so simple. The complications depend on the cause, the date of the appearance of the hernia, its progress, the state of health of the infant, and its social condition.

Frequently the cause is to be found in st:umous diathesis or in premature birth. In the first case the consolidation of the umbilicus is hindered by the flaccidity of the abdomen, and the hernia will not disappear spontaneously unless the food and hygienic conditions are improved. In the second, a spontaneous cure depends on the manner in which the chil l is nursed. If by the mother, the chances are that the infant will grow up normally, but if it is sent out to nurse or artificially fed, the hernia will probably not recede, if the child does not die itself.

The younge· the child, the more chances has the hernia to get well spontaneously; the older it is the more surgical treatment will be necessary.

During the first months of life, the umbilical ring commences to cicat ise, and the elements of which it is composed are being gradually transformed into compact fibrous tissue narrowing more and more the opening. On the other hand, according to Professor Berger, the calibre of the intestines increases while that of the umbilicus diminishes, until the aperture is completely closed. At the age of eighteen months or two years, the consolidation is terminated. If on the contrary the orifice remains as it is, the intestine escapes through and the tendency to spontaneous cure diminishes.

As to the mode of development, a hernia which remains small gets well without interference; but if it is comparatively voluminous and becomes irreducible at times, if the omentum penetrates it in too great abundance, the hernia will not recede spontaneously.

Besides, it may get well to all appearances, but it is only in appearance, and later on in adult life, especially in women, when pregnancy weakens the walls of the abdomen, it will re-appear with all the gravity of adult hernia. Adult umbilical hernia, says M. Berger, is frequ ntly nothing else than infantile hernia which had appeared to get well, but had returned after many years.

The prognosis of umbilical hernia depends a'so on the state of health of the child. If it is in good condition, fed properly and not weaned, every chance is on his side. If, on the contrary, he is given as soon as he is able to sit at table with his parents, meat, wine, potatoes, cabbage, etc., to "make him strong," the chances are that rickets will set in and compromise considerably the cure of the hernia.

Acute affections eruptive fevers which weaken the child, bronchitis, pneumonia, exercise an unhappy influence by attacking the general condition and provoking cough.

BLUE LIGHT.

The employment of blue rays as an agent of hypnotism was tried for the first time by Dr. Redard, of Geneva. M. Cavalié, of Borde ux, explains how to operate to obtain from this new method the best results.

An electric lamp of sixteen candles, of which the glass is intensely blue and as pure as possible, should be procured. The patient should be prepared for the experiment by assuring him that he will not be put to sleep, but momentarily deprived of feeling. The confidence of the patient is an important condition of the success desired.

The person to be operated on is seated in an armchair, and the lamp, furnished with a good reflector, is placed at a distance of four to five inches in front of his eyes, and a blue calico covering thrown over his head and the lamp, so as to prevent the daylight from penetrating.

The patient is enjoined to fix his eyes strongly on the blue lamp for two or three minutes, when his face will turn pale, and the pupils dilate. The patient seems to have fallen into a trance. It is at this moment that the operation should be commenced and rapidly terminated, as the insensibility only lasts about thirty seconds. Frequently the patient is surprised to have felt no pain from the operation, although he was not put to sleep as he had expected.

This method is admirably suited to the extraction of teeth, and is, of course, entirely free from danger.

M. Cavalié had operated thus already forty times, and almost always with success. The few unsuccessful cases were attributed to the want of confidence of the patient or a fault in the way of fixing the eyes on the blue lamp.

THYMOL AND APPENDICITIS.

Professor Guiart, affirming that appendicitis is almost always of parasitic origin, esteems that it can be cured by a simple vermifuge. He recommends thymol in large doses followed by a saline purgative, and has always obtained a cure by this treatment, which is applicable to every case of appendicitis.

The thymol is given in 15-gr. doses three times a day during three days, after which a purgative is given. The thymol is given in wafers, and the patient is ordered to drink only water during these three days. It is well accepted by the patients, who can continue their ordinary mode of living after the fourth day.

In severe cases M. Guiart gives the thymol every hour for two or three doses.

The patients are forbidden to use for a week, oil, glycerine, acetic acid, chloroform, ether, and particularly alcohol, as thymol is soluble in these liquids and poisoning might result from its absorption.

The treatment can be applied to typhoid fever and all kinds of intestinal wounds.

GERMANY.

Berlin, Dec. 9th, 1906.

THE INFLUENCE OF GASTROENTEROSTOMY ON ULCER AND CARCINOMA OF THE STOMACH.

THE discussion on Hr. Katzenstein's paper on this subject was resumed by Dr. Biekel, who remarked that the cause for the differences of effect from gastroenterostomy in the human subject and in dogs must still be investigated; possibly the difference in position played a part. Examination of a large number of cases made it probable that the disturbance present in ulcer of the stomach did not depend so much on the percentage of hydrochloric acid as on an increase in the normal acid juices.

Hypersecretion might be combated by (*a*) alkalies, atropine, and other poisons; and (*b*) by regulation of diet. He had caused comparative investigations in regard to the secretory effects of different forms of diet to be made by Frau Robinowitsch. A mixture of butter, sugar, and white of egg appeared least to excite secretions. The indications for gastroenterostomy for ulcer should not be widened. In acute hæmorrhage there might be no ulcer, the bleeding being perenchymatous. He related two cases of this kind. The frequency of ulcer had also diminished recently, as shown in the Charité statistics. In 1,399 sections three were only two cases of ulcer, but thirty-four of carcinoma.

Hr. Elsner held Hr. Katzensten's investigations to

be of extraordinary value. He related a case in which, after gastroenterostomy, an ulcer of the jejunum developed from the action of the gastric juice, the symptoms from which did not disappear even after a second operation. Here, perhaps, the diet of fats and carbohydrates recommended by Katzenstein would have resulted in an increase in the pancreatic secretion, and compensation. He thought that in carcinoma of the fundus life might be prolonged by operation by relief afforded by perist.lsis.

Hr. Fulda was of opinion that Katzenstein's investigation had contributed to the enrichment of our internal treatment by the administration of the secretion of the small intestines and by the dietetic prescriptions. They would scarcely lead to the frequent employment of gastroenterostomy. In England it must be borne in mind that gastroenterostomy was not so frequently performed for gastric ulcer as formerly. The result mentioned as regarded carcinoma depended not infrequently on self-deception.

Hr. Fedo Krause thought the whole material of a hospital presented a truer view than selected cases, and he would mention those of the Augusta Hospital. During the six years of his activity in Berlin, himself and his assistant had performed 213 operations on the stomach. A not inconsiderable number of the cases were in such a condition that the operation was of vital importance. In such cases there was no longer any question of gastric function. The pylor s was closed, or nearly so, by carcinoma, by firm cicatrices, and infiltration resulting from old ulcers. In cases of chronic ulcer with repeating hæmorrhages, or in the case of the rarer profuse hæmorrhage, observation and waiting on the adoption of any other treatment than operation was impossible. In such cases the prognosis was naturally bad. Without procuring a well-acting new connection between the stomach and jejunum, these patients were irretrievably lost.

Amongst the 218 stomach operations were 142 gastrostomies—87 for carcinomatous occlusion of the pylorus, 55, for ulcer and its sequelæ. A diagnosis as to whether the case was one of cancer or extensive cicatricial infiltration was not always possible, even after opening up and examination of the diseased organ. A case might therefore be put into the wrong category. But as such an error of diagnosis would be just as frequent in the case of carcinoma as in cicatricial infiltration, the figures given would scarcely undergo any change, even if a microscopic examination had been made in every case.

Of the cases operated on for carcinoma, 41 (=47 per cent.) died; of those operated on for ulcer only 5 (=9 per cent.) died. The more frequent cause of death was cardiac failure, and the *post-mortem* examination almost always revealed brown atrophy. The second most frequent cause of death was inflammation of the lungs; peritonitis could be avoided by careful asepsis.

The high mortality in cancer was due to the wide-reaching indications. In very feeble cases he considered operation justifiable, otherwise the patient would not die of cancer, but from starvation. As regarded results in cancer cases, an increase in weight of 20 kgrm. and over had been observed, and a number of the cases had been able to return to work. That tumours grew less rapidly after all sources of irritation were removed could not be disputed.

The permanent results of the operation on the ulcer were thoroughly satisfactory, sometimes even surprising. Peptic ulcer was not so common that it need be looked upon as a danger. The speaker had met with two cases, and they taught that strict dietary was necessary, and that if there was hyperacidity it must be overcome.

Hr. Litten said that hæmorrhage might be caused by disease of the liver, cirrhosis, or syphilis, and these conditions could not always be diagnosed, and years ago he had indicated varices in the lower part of the œsophagus as sources of hæmorrhage. The occurrence of capillary hæmorrhage had been disputed, but he had now seen two cases in which the bleeding was of this character.

Hr. Ewald said that acidity of the stomach could only be estimated as to percentage, not actua quantity.

Hr. Katzenstein, in reply, said that trypsin did not act in a strongly ac d solution. The acidity of the stomach should be tested an hour and a half to two hours after the test breakfast.

The difference of posture of men and dogs had nothing to do with the secretion. Peptic ulcer could be avoided by following the speaker's rules as to diet. He had no intention of widening the indication for operation. but where internal treatment could not succeed, the surgeon should come in. By testing the cardiac function in the way proposed by himself, cardiac collapse could be avoided; the operation could be postponed until such time as the heart was strengthened, or no general anæsthesia should be e mployed, or æther narcosis in place of chloroform.

AUSTRIA.

Vienna, Dec. 9th, 1906.

A MUSCULAR ARTIST.

At the "Gesellschaft," Haberer showed a man, æt. 32, with a wonderful power over his muscular system. By an effort he could place all the small intestine to one side of the abdomen or the other at will. He could throw all the contents of the abdomen under the diaphragm, or into the pelvis, resembling a female in the last month of pregnancy. By the same contractions he could pass waves along the abdomen like a worm, or make the sternum bend in like a cobbler's breast, or pigeon-like, resembling the strumous. With the sternothyroid and hyoid he could produce goitre; move the heart from one position to another; spontaneously dilate the pupils; and compress the subclavian artery and obliterate the radial vessels.

Altogether he thought this would be a dangerous patient to treat in critical circumstances.

SCLERODERMA.

Neurath showed a child, six weeks old, with an elastic swelling, which commenced about the end of the first week after birth. It affected the lower extremities, and ceased sharply at the umbilicus. The breast and shoulders, as well as the arms, except at the distal extremities, were perfectly normal. The latter changes commenced a few days ago. The face has also a slight puffiness. The œdematous parts were thick and firm with a porcelain appearance, but never cyanotic. At first it was white or yellowish red, cool, and without any folds. Strong pressure with the point of the fingers produced a very slight depression. This thickening was greatest on the instep, calf of the leg, scrotum, and penis.

INFANTILE SCORBUTUS.

Escherich presented two children with what he termed Barlow's disease. Neither of the children had the morbid condition fully developed, but the early symptoms were undeniable, hæmaturia being specially diagnostic. In both cases the point of special interest was the malnutrition, although the food provided had been ample and sufficient. The clinical phenomena resembled the disturbed metabolism met with in rachitis, though the increase of the skeleton portion resembled the scorbutic state of the adult, which was supported by analogous changes in the blood. Escherich thought this was not exactly a case of scorbutics, but rather one of Barlow's disease, as the change of diet alone produced a rapid improvement in the child's health.

OSTEOMALACIA.

Katholicky showed Röntgen photographs and microscopic preparations of a case of osteomalacia resembling Paget's disease. From the symptoms and preparations of the bony structure, he doubted whether it was Paget's osteomalacia chronica deformans hypertrophica or Recklinghausen's ostitis deformans fibrosa. Kolisko thought the difference lay in the inflammatory changes with the hyper-ostotic bony thickening. Latzko differed from this opinion, and thought that the

pathological change in the bone was not sufficient, but that the anatomical etiology should determine the difference. Paget's ostitis and Recklinghausen's deformans with the tumour formation were altogether different processes. In the one giant carcinomatous cells, in the other pure osteomalacia. He thought the case presented was one of Recklinghausen's simple osteomalacia deformans. Sternberg had histologically examined the cases, and found no sarcomatous cells. Kolisko thought the giant carcinomatous cells an unsatisfactory quantity, as many cases healed spontaneously when these were present. Habera always found the diagnostic carcinomatous cells on the cystic enlargements of the tumour.

HUNGARY.

Budapest, Dec. 9th, 1906.

On the 15th and 17th of this month there was held, at Budapest, in connection with the meeting of the Hungarian medical societies, a first National Congress of Cancerous Diseases. The opening meeting took place in the building of the University, where Professor Dr. Dollinger received the guests, who came together from every part of Hungary. Dr. Dollinger began the formal business of the Congress by delivering an address dealing with the occurrence of cancer among the working-class. This disease, although visiting royal houses, too, is most evident in the poor classes (owing to the want of cleanliness, perhaps), and is popularly supposed to be confined almost entirely to persons who live in crowded houses in bad hygienic conditions. This fact favours the correctness of the theory of the communicability of cancer.

In 1904 cancerous patients were conscripted in Hungary, and as the Statistical Bureau stated, there were 3,570 living cancerous patients in that time. But this number is not reliable; actually, there were many more than that.

Speaking about the treatment of superficial cancers, he said that he favours early excision, or, if the patient comes in a later stage, the application of a ray of sufficient intensity for a sufficient length of time. This is capable of causing a disappearance of the tumour and carcinomatous cell nests and their replacement by connective tissue, a proliferative, obliterative endarteritis, and a sclerosis of the lymph vessels and glands leading from the affected part. A course of radiation not to exceed ten treatments of twenty minutes each, at a tube distance of eighteen inches, is sufficient in the majority of cases to accomplish the desired results.

He ended his paper with the emphasising of the necessity of early diagnosis, and on the basis of this early operation. It is a shame to every family doctor to wait and allow a cancer case under his care to go on to the inoperable condition.

Dr. Alexander Korányi discussed the

Early Recognition of Cancer of the Stomach, and its Treatment.

He said that there is no truthfully recorded example of a cancer of the stomach cured by medical means, yet these cases are treated by medical men, and are sent into the medical wards and subjected to treatment which must result in 100 per cent. mortality. Cancer of the stomach is the most frequent form found in the human body, at least 30 per cent. of the total, a tremendous sacrifice of human life almost without effort at cure. The past high mortality of radical excision and the difficulty of early diagnosis, are largely to blame for this state of affairs. Since 1900 great improvement in technique has lowered the mortality to less than 10 per cent., and exploratory incision in the suspicious cases gives the diagnosis. If more internists saw operations upon cancer they would advise operation sooner than they do. The ordinary methods of diagnosis are not especially effective or certain for early dagnosis, though the absence of hyperleucocytosis after digestion, and the presence of lactic acid are helpful. Careful examination of the vomit may be pathognomonic. Indigestion is not always a surgical disease, neither is it always a medical disease. Persistent symptoms from the gastro-intestinal tract mean serious involvement of the gall bladder, the pancreas and the stomach, in nearly every case. It is important then, for the pysician to insist on consultation with the surgeon if the symptoms persist after careful treatment for some time.

Besides these, there were several dissertations held on the ætiology, histology, and the treatment of cancer.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Election for the Direct Representation of Scotland on the General Medical Council.—The result of this, as officially announced has given Dr. Norman Walker a substantial majority over Dr. Bruce Dingwall, the sitting representative. Dr. Walker has worked hard for, and deserved success; we doubt not that he will do excellent work for the profession on the General Medical Council.

Epidemic of Conjunctivitis in Aberdeen.—Considerable anxiety is being caused the sanitary and educational authorities of Aberdeen by the extensive prevalence of conjunctivitis among the children of the city. The matter has been brought prominently to public notice through letters to the press from the pen of Dr. Galloway, insisting on the responsibility for this state of matters resting on the School Board, who have not, he thinks, taken adequate precautions against the dissemination of the infection in the schools. The epidemic seems to have been going on for nearly a year, and attained its greatest severity in August and September. The best way of dealing with the epidemic is now under the consideration of a committee of the School Board, who seem, not unnaturally, to resent Dr. Galloway's action in writing to the press without previously laying the matter before the school officials. In a letter dated November 20, addressed to the clerk, Dr. Galloway states that at the Dispensary six new cases of trachoma had appeared during the past two days. Dr. Galloway suggests that the Board should send a clerk to the Dispensary to take names and addresses of children while the epidemic lasts. The occurrence of trachoma is a sufficiently serious matter to warrant active measures being taken, and now that public attention has been drawn to the matter, it is probable that the epidemic will soon be overcome.

LETTERS TO THE EDITOR.

MEDICAL EVIDENCE IN LAW-COURTS.

To the Editor of The Medical Press and Circular.

Sir,—It is difficult when we are giving evidence in a Law Court or before a Commission to create the impression amongst the jury or the members of the Commission that we are independent of all influence or interest but that of accurate observation. A witness can rarely be regarded as wholly disinterested on one side or the other. In your article on Slate Quarrymen and cardiac dilatation (December 5) you have taken the view that it would be well to leave the matter in the hands of "practitioners capable of throwing a deal of valuable light upon the question"; and as it requires a good pathologist to deal with it from a medical and pathological point of view, you can understand how little inducement there is to submit our clinical observations to a jury or committee of ignorant if not prejudiced laymen, whose knowledge of matters medical is often ludicrously childish. Up to the present time I have personally dealt with the subject in the usual clinical manner, observing the symptoms and various organic derangements presented in the cases. It remains now to work out the relations between conditions and causes; and it is

clear that the latter vary much among the quarrymen in Wales, from the variety of the work they are engaged in. This opens up, of course, a desire to know and see how the various kinds of work in stone and slate vary in their effects on the bodies of the men who follow them, and I hope that your article will lead to more useful inquiry into this part of the subject.

I am, sir, yours truly,

ROBERT LEE,

Pwllheli, December 8, 1906.

OBITUARY.

FREDERICK ABELL HUMPHRY, F.R.C.S., L.S.A.

WE record with sorrow the death on December 3rd of Mr. Frederick Abell Humphry, F.R.C.S., who formerly had a large medical practice at Brighton, and resided in Marine Parade. Mr. Humphry, who was 76 years of age, moved to Crowborough some years ago, and took interest in everything that concerned that health resort, but he did not himself actively engage in public matters. Mr. Humphry was educated at Cambridge University and St. Bartholomew's Hospital, and took the M.R.C.S. and L.S.A. in 1853. After holding the post of house-surgeon to the latter institution, he took the F.R.C.S. in 1856, and subsequently went into practice at Brighton. For many years he was surgeon to the Sussex County Hospital, and enjoyed a large practice.

RASHLEIGH BELCHER, L.F.P.S.Glasg.

WE regret to announce the death at his residence, Garston, Liverpool, on Wednesday evening, of Dr. Rashleigh Belcher, a well-known medical practitioner. Dr. Belcher was 58 years of age, and settled in Garston about twelve years ago as partner to Dr. Haythorne, whom he subsequently succeeded. About three weeks ago he caught a severe cold, but did not take to his bed till a week ago, when bronchitis set in. Subsequently he appeared to be recovering, but on Wednesday morning he had a relapse, became unconscious, and died shortly afterwards. He leaves a widow and son and daughter to mourn his loss.

ARTHUR GOODWIN, M.R.C.S.I.

WE regret to record the death of one of Hanley's oldest medical practitioners in the person of Mr. Arthur Goodwin. Mr. Goodwin contracted blood poisoning about twelve months ago, and since that time had always been in indifferent health. He practised, however, up till a few weeks ago, when cystitis, a painful malady, caused him to take to his bed. Mr. Goodwin went to Hanley from the Chesterfield district of Derbyshire, and had been in practice in the borough about 35 years.

SPECIAL ARTICLES.

THE MEDICAL MAN AS SOCIAL REFORMER.

When some future Buckle comes to write the history of civilisation in the nineteenth and twentieth centuries, one of his duties will be to chronicle the actions of the medical profession as an agency, direct as well as indirect, in social reform. For the most conspicuous example of this we must look to Russia. The Zemstvo doctors and their work are the great glory of Russian medicine of to-day, beside which even the epoch-making researches of Pawlow pale. The emancipation of the serfs was the signal for thousands of devoted men and women going to spend their lives as physicians among the most degraded peasantry in the world, with the avowed object not of earning a livelihood; but of spreading enlightenment and improving the conditions under which the moujik lived. Oppressed by the governing class as instruments of the hated reform, thwarted, persecuted and sometimes even massacred as the causes of pestilence by a superstitious people, these men and women suffered martyrdom only to see new comrades step into the gaps in their ranks, and now much of the improvement in the conditions of the masses in Russia must be ascribed to the work of the Zemstvo doctors. To come nearer home, and happily to far less tragic circumstances, we find the same thing happening. In the remoter parts of Ireland and Scotland we every now and then hear of self-sacrifice no less than that of our Russian colleagues. We know too, that in every peasant community the doctor, with his scientific outlook, is the reformer as well as the physician. Dr. Lachlan Grant, whose name came prominently before the public in connection with the Ballachulish dispute, in which his manly fight for the rights of his patients excited general sympathy, has, through his outspoken utterances in favour of social reform in the Highlands, been instrumental in founding a "Highland Crofters' and Cottars' Association," whose objects are to assist in the industrial development of the country, to arrest depopulation, and, collectively, to promote the interests of the people. A medical journal has no politics, and the main objects of the association depend for their attainment on political means. The nationalisation of the land, for instance, is a thorny subject, and on this and other parts of the Association's programme we naturally express no opinion. But, when it comes to medical matters, there we see eye to eye with Dr. Grant. It is quite notorious that medical officers of health are hampered by unprogressive local authorities, and that, rate and tax as you may, a poor locality simply cannot find the money needed for efficient sanitary administration. Moreover, sanitary administration urgently requires to be compulsorily extended so as to include the physical inspection, and, where necessary, the feeding of school children, particularly in sparsely populated districts. Again, some system of State medicine seems imperatively demanded in the outlying districts of the Highlands. As we have said, apart from the obstacles arising from innate conservatism, the financial difficulty in poor, sparsely populated districts is under present conditions insuperable. Somewhere or another, Mr. H. G. Wells wrote an admirable paper on Larger Administrative Areas, which went very much to the root of these questions. The present areas of administration are really relics of a past age when means of intercommunication were few. Now, with improved transit, the whole country has become much more homogeneous. In the case in point, it can hardly have escaped any observant sojourner, say, in Inverness, that the Highlander looks to London as his trading centre rather than to Edinburgh or Glasgow, and in the Highlands during the summer, even in the most remote parts, you will hear the soft southern accent nearly as frequently as the Gaelic. We have to realise that the efficiency of the nation depends on the prosperity of its individual communities. The Highlands are the playground of the dwellers in cities, who go there to gather health for the strenuous life of the town. The towns, on their part, draw from the manhood of the country the replenishment they need. Stated thus, there seems to be a good case for a more uniform distribution of burdens—for that, after all, is what State aid means.

VITAL STATISTICS IN IRELAND.

THE report of the Registrar-General for Ireland for 1905 (*a*) has recently been issued, containing as usual a well-arranged summary of the work of the Register Office during the year. The Registrar-General again acknowledges his indebtedness to Dr. Ninian Falkiner, the Medical Superintendent of Statistics, for his aid, and medical readers will agree that the information of special interest to them has received a due amount of attention.

The report has again to admit a decrease of population. The estimated population in the middle of the

(*a*) "Forty-Second Detailed Annual Report of the Registrar-General for Ireland." Dublin: H.M. Stationery Office. 1906.

year was 4,391,565, as against 4,402,182 in the previous year, and an average of 4,481,504 for the ten years 1895-1904. In the course of the year the marriages registered in Ireland numbered 23,078; the births, 102,832; and the deaths, 75,071. The marriage-rate, which is 5.26 per 1,000 of the estimated population, shows an increase of 0.04 as compared with that for the year 1904, and is 0.20 above the average rate for the ten years 1895-1904, and the highest rate for any of these years; the birth-rate (23.4 per 1,000) shows a decrease of 0.2 as compared with that for the preceding year, but is 0.2 above the average rate for the ten years 1895-1904; and the death-rate (17.1 per 1,000) is 1.0 under the rate for the preceding year, and 0.9 under the average rate for the ten years 1895-1904. It appears, therefore, that the natural increase of population, or excess of births over deaths, was 27,761; the loss by emigration amounted to 30,676; a decrease of 2,915 in the population would thus appear to have taken place during the year.

There is not a complete record kept of the age of marriage, the law being satisfied by the entry of "minor" or of "full age" in the age column.

Of 23,078 men married during the year, 321, or 1.39 per cent., were minors; and of the women married 1,368, or 5.93 per cent., were under age. Of those married under age in 1905 the highest proportion of husbands (1.80 per cent.) and of wives (7.39 per cent.) was in the province of Ulster. It is observable that the percentage of persons married in Ireland who were under age is very far below the corresponding percentages in England and Scotland. These facts are, of course, in keeping with the observation that the marriage age is lower in an industrial than in an agricultural community. That a greater number of marriages take place in an industrial people is shown also by the fact that the marriages registered in proportion to population at all ages were most numerous in the province of Ulster, in which, however, the rate was only 5.7 per 1,000 of the population, according to the Census of 1901; Leinster comes next with 5.5 per 1,000; Munster third, with 4.7 per 1,000; and Connaught last, the rate being 4.1 per 1,000. The births registered during the year 1905 numbered 102,832—52,509 boys and 50,323 girls, or 104.3 of the former to every 100 of the latter—the rate afforded in proportion to the estimated population being 1 in 42.7, or 23.4 per 1,000, which is 0.2 above the average rate per 1,000 for the ten years 1895-1904. Of the 102,832 children whose births were registered in Ireland during the year 1905, 100,122, or 97.4 per cent. were legitimate, and 2,710, or 2.6 per cent., were illegitimate, being equal to the corresponding average percentages for the preceding 10 years. These results compare favourably with the returns for most other countries.

The deaths registered—75,071—were equal to a rate of 1 in 58, or 17.1 per 1,000 of the estimated population. The counties or county boroughs having the highest rates of mortality are Dublin County Borough, 23.1; Belfast, 20.4; Armagh County, 19.3; Wexford County, 18.5; and Tyrone County, 17.7.

Among the causes of death tuberculosis still holds first place, 11,882 persons having died during the year. Taking the mortality of the disease in relation to the mortality from all causes, it will be found that of every 100 deaths 16 were due to tuberculosis. The Registrar-General emphasises the fact that whereas in England and Scotland the death-rate from tuberculosis has gone down by nearly a half in the past forty years, in Ireland the rate now is higher than it was in 1864. Another point of contrast is noted. In England and Scotland the highest rate for tuberculosis is found in the population under five years of age; in Ireland it is found in the population between 25 and 35.

Curiously enough, the cause of the greatest number of deaths, after tuberculosis, is old age, which was responsible for 8,641. From heart diseases 8,170 died, and from bronchitis 7,462.

The year shows a further increase in the number of deaths from malignant disease. The aggregate was 3,291, in contrast to 3,055 in the previous year. Of the deaths in 1905, 1,443 were deaths of males, and 1,848 of females. The site of the disease was the stomach in 782 cases, the intestine in 183, the rectum in 180, the liver or gall bladder in 437, the uterus in 209, and the breast in 324.

The value of the report is increased by a series of instructive charts and diagrams.

NEW INVENTIONS.

WRIGHT'S COAL TAR INHALER.

On theoretical grounds the treatment of the inflamed mucous membrane of the air passages by medicated vapours commends itself to the physician. In practice, however, that particular method has not come into the general use that it apparently deserves. This neglect has doubtless been largely due to the lack of convenient and efficient apparatus for vaporisation. Messrs. Wright and Co., the well-known makers of coal-tar soap, have devised a simple plan for diffusing the vapours of coal-tar both for direct and for general inhalation. The apparatus is extremely simple, consisting of a metal receiver heated by an ordinary nursery night-light. Into the receiver is placed an absorbent block saturated with the coal-tar preparation, and any other drug, such as menthol, that it may be considered advisable to add. This inhaler is well worth an extended trial in bronchitis and other affections of the respiratory tract; but, above all things, in measles, influenza, and whooping cough, in each of which there is a definite source of local irritation in the shape of a specific pathogenic bacillus. The vapour given off from the inhaler may be inhaled directly, or may be diffused through the atmosphere surrounding the patient.

REVIEWS OF BOOKS.

TREATMENT OF CANCER. (*a*)

Dr. Shaw Mackenzie's views on the treatment of cancer, and the work he has done on the subject, are so well known that we need not do more than mention that his little book has now reached a fourth edition, a testimonial in itself to the amount of interest displayed by the profession. There is little that is new in this edition, and the whole subject is still in a tentative condition, so that the wise course is still to suspend judgment. Dr. Shaw Mackenzie's methods are, we believe, being extensively tried, and doubtless the experience of a few more years will decide how much of permanent value there is in them. In inoperable cancer no reasonably founded treatment is lightly to be rejected, or embraced.

LE SOL ET L'EAU. (*b*.)

This volume is the second fasciculus of the Traité d'Hygiene, which is being published monthly under the direction of MM. Brourardel and Mosny. In some respects this particular number forms a striking contrast to the works dealing with the subject at present in use. The different sections of the work are entrusted to men exceptionally well-informed on the portion for which they are responsible, and with one exception each department receives its fair consideration. The microscopical examination of the sediment is practically limited to the detection of intestinal worms, which the authors appear alone to regard as worthy of note.

The geological study of the soil by M. de Launay contains a warning against reliance on single analyses of water, which ought to be more widely appreciated in this country. He explains fully the influence of the soil in determining the character and potability

(*a*) "The Nature and Treatment of Cancer." By John A. Shaw-Mackenzie, M.D.Lond. Fourth edition, revised. London: Bailliere Tindall and Cox. 1906. 2s. 6d. net.

(*b*) *Le Sol et L'Eau.* By L. de Launay, Professor at l'Ecole de Mines; E. A. Martel, of the Comité Consultatif d'Hygiene; Ed. Bonjean Chef du Laboratoire du Comité Consultatif d'Hygiene de France; and J. Ogier, Chef du Laboratoire de Toxicologie de la Faculté de Medicine de Paris. Pp. 460. With two coloured plates and 80 illustrations. Paris and London: Bailliere, 1906. Price 10fr.

of the water. Two geological charts are fully explained, an example that is worthy of note, and which might be followed by English writers with advantage.

M. Bonjean deals with the physical, chemical and bacteriological action of the soil, and its bearing on the quality of the water. He gives especial attention to diseases of a reputed telluric origin.

M. Martel explains the circulation, emergence and contamination of subterranean waters, including a discussion on the use of flourescein as a means of identifying distant pollution, and the legal means for the protection of water supplies. The bacteriological, chemical, and microscopical methods of analysis are given in a compact form by MM. Ogier and Bonjean. The interpretation of results deservedly occupies a considerable space, as also does the article on water filters.

The D.P.H. candidate will turn with relief to this book. He will glean information either unknown or ignored by English writers; he should appreciate the romantic side of water supply, and will surely be grateful for the freshness of treatment of the subject. We know of no book on the subject so interesting, and its perusal will well repay all who can read the French language, and are interested in the bearing of water supply on public health.

DISEASES OF CHILDREN. (*a*)

IT used to be said, and we believe there are those who still maintain, that Great Britain is behind her civilised neighbours in her knowledge of, and practice in, diseases of children. The justification of this charge we are still seeking. True it is that the State has not realised its responsibility towards children in the same way that, for example, France and the Australian colonies have, but that British physicians and surgeons lag behind their *confrères* in skill in and acquaintance with, pediatrics we refuse to believe. The book before us is one written by a distinguished Austrian professor, which has had a wide sale in German-speaking countries, and it has now been translated and edited by an American physician of eminence. It may, then, not unfairly be taken as representing the last word of these countries—the ones that we are specially compared with to our detriment—on the subject with which it deals, and we can say without any disparagement to the book that while we cordially agree with its teaching as a whole, we are not conscious of having learned anything particularly new from it. The translation has been really well carried out, the book being done into good idiomatic English (or, dare we say, American?), while its value is distinctly enhanced by the editor's pithy notes. The work is arranged on the dictionary plan, diseases medical and surgical being treated of in alphabetical order. The descriptions are short and to the point, but so much has had to be inserted that there have necessarily been great sacrifices made in individual articles in the cause of brevity. Indeed, the qualified practitioner who wishes to know a little more than he is already familiar with will probably find the book unsatisfying, although for the student who is breaking new ground it is admirably adapted. He will find the article on congenital syphilis of great help, but the important subject of tuberculosis touched upon rather too lightly. Whatever may be the rule in Austria and America, we do not call cases of scarlet fever in which widespread gangrene of the oral and pharyngeal cavities developes "scarlatinal diphtheria" (page 414). We confine the latter term strictly to conditions associated with the Klebs-Löffler bacillus, and it is certainly the more convenient practice. The illustrations, as is the rule in Messrs. W. B. Saunders and Company's books, are clearly and well reproduced, but we are sorry to see in the appliances for infant feeding the objectionable artificial nipple attached to a long tube exhibited in one of the plates. The work is a handy and serviceable one, but it does not make us blush for British pediatrics.

(*a*) "Reference Handbook of the Diseases of Children." For Students and Physicians. By Prof. Dr. Ferdinand Frühwald, Chief of Clinic in the Vienna Polytechnic. Edited, with additions, by Thompson S. Westcott, M.D., Associate in Diseases of Children in the University of Pennsylvania. With 176 illustrations. Philadelphia and London: W. B. Saunders and Company. 1906.

ROYAL ARMY MEDICAL CORPS (*a*).

THIS guide is compiled with the object of assisting men of the Army Medical Service to make up their work for promotion examinations. Most of the subject matter is, therefore, to be found in the two Army publications with which they are expected to be familiar, namely, the Manual, and the Standing Orders of the Royal Army Medical Corps.

Part I., comprising half the text, consists of an exhaustive series of questions and answers on drill, discipline, etc., and is required for the first examination for non-commissioned officers. Instruments and appliances are suitably illustrated. Part II. deals with the additional subjects the knowledge of which is necessary for promotion to sergeant.

The Appendix (pp. 260—303) is a guide to the recently-promoted N.C.O., and contains instructions for routine clerical duties, and shows the method of filling up various official forms.

The Guide is sure to find favour with those for whom it is intended, except, perhaps, in the matter of price, as it is concise and comprehensive.

KIRKBY'S PRESCRIBING (*b*)

THIS is the second edition of a little work, the first of which was well-received. In these days, when prescription-making is gradually being lost sight of, it is refreshing to meet with books such as this which tend to prevent its complete disappearance from the medical curriculum. Students are grossly ignorant regarding this very important subject, mainly because it is badly taught or very often not taught at all in many of our medical schools. The little book before us gives a very thorough account of its subject. Incompatibilities, solubilities, and the various pharmaceutical preparations are very comprehensively described and explained. Under each pharmacopœial remedy a list of its more important incompatibilities is given. Some of the substances used in medicine are given in a list by themselves, and under each is placed a reference to the impurities which they may contain. A number of exercises in practical dispensing and in the testing of drugs have been added, and the student who can carry out these satisfactorily will have no difficulty in performing this part of his duties in actual practice. This edition has been enlarged and extended, but otherwise the book remains the same as before. We wish it were used in every medical school throughout the country by students before presenting themselves for their final examination. We congratulate the author on his efforts to raise the standard of prescribing and dispensing amongst medical students; and trust this edition will meet with even greater success than the last.

CLIMATIC TREATMENT. (*c*)

DR. HUGGARD, in his "Climatic Treatment," has set himself a bold task, namely, "to place the therapeutics of climate on a secure foundation," which seems to us about as ambitious as trying to place religion or philosophy on a secure foundation, and as hopeless. Still, it is well to have ideals, and Dr. Huggard's ideal not only is a noble one, but he has

(*a*) "Guide to Promotion for Non-Commissioned Officers and Men of the Royal Army Medical Corps, with Appendix on Hints for young N.C.O.s." By Capt. S. T. Beggs, M.B., Royal Army Medical Corps (M), formerly House Surgeon and House Physician, Royal Victoria Hospital, and Demonstrator of Physiology, Queen's College, Belfast; Examiner and Lecturer, St. John's Ambulance Association, &c., &c. 1906. London: Gale and Polden, Ltd. Pp. 303. Price 3s. 6d. net.

(*b*) "Practical Prescribing and Dispensing for Medical Students." By William Kirkby, sometime Lecturer in Pharmcognoscy in the Owens College Manchester, Second edition. Manchester: Sherratt and Hughes.

(*c*) "A Handbook of Climatic Treatment, including Balneology." By William R. Huggard, M.A., M.D., F.R.C.P., H.B.M. Consul at Davos, Switzerland. London: Macmillan and Co., Ltd. 1906. 12s. 6d. net.

succeeded in writing the best and most useful book we know on climatology and balneology. But we should be sorry to say that the therapeutics of climate are thereby safely secured to our children's children. Indeed, it is probable that people would rather resent being told that their favourite spot was not good for rheumatism because of its high relative humidity, when they have been there over and over again, and been cured of their rheumatism. And it is quite impossible, as every practitioner knows, to get people to "believe" in a place that they do not like. The fact is, that the social and human environment is as large a factor in almost any "cure" as the amount of calcium carbonate in the water or the proportion of sunny days in the year. We have no doubt that the analysis of the waters of Abana and Pharphar would have been found to differ but slightly from that of Jordan; in fact, the quantity of albuminoid ammonia in the latter was probably disquietingly high; but the Jordan cured and Abana and Pharpar did not. Which is another way of saying that the element of charm in a place is a great factor in the cure of the patient, as is the element of confidence in the physician, or any other obligatory condition. Charm defies analysis, and is as likely to do so as long as one lady finds that Falmouth in the winter braces her up, and another that the mistral is the most helpful factor on the Riviera for the restoration of health. But we are far from saying that the scientific study of climatology is not desirable; it is eminently so, and Dr. Huggard's book before us is one of the few works in the language which preserves a sane and judicial outlook over the competing claims of spas and watering-places. Moreover, the knowledge of the author is sufficient to enable him to systematise and lay down general principles, and he may confidently be looked to for wise and tolerant advice as to the most promising line to be followed in treatment. Among all the information the author has collected, it is hardly surprising that minor errors should have entered, but these are neither numerous nor serious. For instance, though it may concern the residents at Hastings and St. Leonard's to know that those towns "belong to the more bracing class of seaside resort," it will not do them much harm, and in the same way, though the inhabitants of Eastbourne might be surprised to hear that their western and south-western downs protect them from the north winds, they would probably only wish they did. But it is well to mark clearly that Dr. Huggard's is not of the ordinary type of climate book—half guide-book and half pseudo-scientific froth—but a praiseworthy diligent, serious study of climatology and balneology by a discriminating physician.

DISEASES OF NOSE AND THROAT. (a)

IF Mr. Parker has waited a good many years before rushing into the thorny paths of systematic authorship, his text-book, now that it has appeared, is considerably the gainer. To write a good systematic treatise even on a special department of surgery needs a life-time of experience and reflection if it is not to be either a re-hash of other people's opinions or a precocious and unsatisfying product of premature ambition. Now Mr. Parker's book is neither of these, but a thoughtfully planned and very carefully written treatise on the diseases of the nose and throat which we unhesitatingly commend to all students and practitioners as a particularly clear and temperate guide. It is not daringly original, nor, on the other hand, pompously platitudinous; but it sails a judicious course between the Scylla and Charybdis which threaten the author of a text-book. As already mentioned, it's chief characteristic is extreme care, the views of others being conscientiously set forth, and the author's own opinions clearly and concisely stated. Mr. Parker has a happy knack of directness of description which enables him, without beating about the bush, to indicate in a few appropriate words all that is needed for a person of ordinary intelligence to grasp exactly what is intended. And this is the quality of all others that goes to the making of a popular and useful text-book. We notice certain minor omissions such, for instance, as the absence of mention of eucaine lactate. The objection that Mr. Parker makes to the use of eucaine, namely, its insolubility, is, of course, not valid now that this salt has been introduced, and we venture to think that eucaine lactate and adrenalin will eventually render the use of cocaine as a routine anæsthetic superfluous. The description of tracheotomy might well have been expanded, for though all the thirteen (or is it thirty?) possible complications need not have been reproduced, in a special treatise one would have expected ampler details than are actually given. The case for and against intubation is fairly stated, and we agree with the author as to the general superiority of tracheotomy for the reasons he gives. We suspect, however, that the author is not fully *au fait* with the practice of intubation, or he would have mentioned the satisfactory method of extraction of the tube by expression, and he would not have omitted the essential detail of tying the child's hands down if a ligature be left strapped to the cheek. The odd statement is made (page 86) that the "complication" of the upper respiratory tract in the acute specific fevers "has no special features peculiar to the fever which causes it." We must in fairness to the author, as judged from the rest of the book, conclude that his pen played him some scurvy trick when he wrote those words. Mr. Parker rightly says that it is somewhat anomalous that the acute infectious diseases should be included in a book of this type, and it is on this excuse that we forgive the statement that Koplick's spots are "frequently" absent in measles, and that the very infectious and highly important involvement of the nasopharynx in scarlet fever is so cavalierly glossed over. The description of adenoid growths and their consequences is particularly good, especially the sections dealing with nasal and palatal deformities. Sinus suppuration is also fully described, and we note that puncture through the canine fossa has given way in the author's opinion to opening through the inferior meatus. This is the general view now; most surgeons seemingly have come round to it. We are glad to see the method of opening a quinsy by thrusting sinus forceps through the soft palate—the only satisfactory way of tapping the abscess—is well described and insisted on. A word must be given to the illustrations. They are very clear and helpful, and though many are old and few are original, they are all well chosen. The paper and get-up of the book are on a par with the high character and judicious teaching of its contents.

(a) "A Guide to the Diseases of the Nose and Throat, and their Treatment." By Charles A. Parker, F.R.C.S.Edin., Surgeon to the Throat Hospital, Golden Square, W. With 255 illustrations. London: Edwin Arnold. 1906. Price 18s. net.

THE DISEASES OF WOMEN. (a)

WHEN a work reaches its fifth edition it is generally supposed to have proved its use and value in the literature of the special subject it treats of. We have perused the pages of this book with very great pleasure. It is written clearly and simply, so that its meaning can be easily understood. It comprises nearly all that is known or can be described concerning the diseases peculiar to women and gynæcological operations. The work is divided into 57 chapters, running over some 523 pages, with a copious index. The printing is good and the volume handy and not bulky. In this edition much new matter has been introduced in relation to chorion, epithelioma, extra-uterine gestation, and tumours of the ovary, including an entirely new section on metastatic cancer of this organ.

(a) "The Diseases of Women." A Handbook for Students and Practitioners. By J. Bland Sutton, F.R.C.S.Eng., Surgeon to the Middlesex Hospital, and Senior Surgeon to the Chelsea Hospital for Women, and Arthur E. Giles, M.D., B.Sc.Lond., F.R.C.S.Edin., Surgeon to the Chelsea Hospital for Women, and Gynæcologist to the Tottenham Hospital. Fifth Edition, with 129 illustrations. Pp. 536. Messrs. Rebman, Limited, London and New York. Price 11s. net. 1906.

MEDICAL NEWS IN BRIEF.

Joint Hospitals Conference of Great Britain and Ireland.

AN important conference of representatives of hospitals in Great Britain and Ireland, of those interested in hospital administration, and of medical men, was held on Dec. 6th in the Botanical Lecture Theatre, University College, to consider the question of hospital reform. A set of proposals drawn up by a joint committee of the British Medical Association and of non-medical representatives of boards of management of hospitals, had already been sent out to various institutions throughout the country, upon which it was considered that reform could best be carried out. One hundred and forty-nine institutions expressed their intention of sending delegates, and twenty-nine announced that they intended to take no action.

Sir William Church, who presided, said that the hospital system as at present administered was greatly in need of reform. Especially was it so with regard to out-patients. The whole question had become more difficult because of its extreme complexity. They had hospitals on every hand appealing to the public in every way for increased funds to meet their needs. They not only asked for funds to meet their existing needs, but for carrying out extensions of the work they were engaged upon. Although it was nothing to do with the subject, he had to say that many hospital advertisements were anything but dignified. What he thought they really needed was co-operation between hospitals, and not competition.

Sir Henry Burdett moved a resolution calling upon the meeting to approve of the principles drawn up and circulated. He thought that an effectual remedy must be applied to the existing evils attaching to free medical relief by hospitals. Medical practitioners were injured by the abuses and misuses of the present system of free medical relief. One great evil was that people of the poorer classes went to hospitals for treatment for trivial ailments which those who had to pay for their doctors would take no notice of. The poor had an idea that disease came from providence, and could only be cured by drugs. That was an idea which ought to be got rid of. Cleanliness and proper feeding were often what were required. Drink had much to do with the question, and the gin palace at one corner of a street and a free dispensary at the other formed one of the enormous anomalies which existed at the present day.

Dr. F. M. Pope, F.R.C.P., who seconded, said that the unchecked distribution of free medical relief had taken away the doctors' patients, and had created an idea that medical attention was a thing not to be paid for, or, if at all, in a very inadequate manner.

Several members did not care to express agreement with the general principles laid down.

The original resolution stood as follows:—"That this Conference of representatives and supporters of hospitals, medical practitioners, and others interested in hospital administratjon in Great Britain and Ireland, approves generally of the principles contained in the proposals drawn up by the Joint Hospitals Committee and circulated to Hospitals in August, 1906." As amended and passed it affirmed that the Conference welcomed the further discussion of the principles laid down.

Dr. G. A. Heron gave it as his opinion that the out-patient evil would be greatly lessened if hospitals would refuse to treat cases where no good could possibly be done.

The amended resolution was carried. A committee was appointed, to act in conjunction with the Hospitals Committee of the British Medical Association, to yet further discuss and consider the proposals for hospital reform. It was proposed to make the Conference an annual affair.

Charing Cross Medical School.

THE distribution of prizes to the students of the Charing Cross Hospital Medical School took place on the 5th inst., Dr. Amand Routh presiding. The Dean (Dr. Christopher Addison) in his report stated that the excellent results obtained by the students in their various examinations had been fully maintained during the past year. Out of some 200 entries there had been an average pass of over 72 per cent. Sir Arthur Rucker then handed the prizes to the successful students, among whom the Governors' Clinical Gold Medal was awarded to W. K. Beaman, the Llewellyn Prize to W. S. Fenwick, the Golding Prize to S. S. Parkinson, the Pereira Prize to W. S. Fenwick and J. W. Heekes (equal), and the Huxley Medal to L. M. Webber, scholarships being gained by B. F. Eminson, N. C. Lake, H. Smith, F. S. Poole, and D. A. Powell. The Principal of the University of London subsequently delivered a short address, in the course of which he congratulated the students on entering a profession which would not only enable them to achieve personal success but to become benefactors of mankind through the alleviation of suffering. The proceedings concluded with a vote of thanks to Sir Arthur Rücker, proposed by Lord Kilmorey, Chairman of the Hospital.

Birmingham Red Cross Society.

To organise a local branch of the British Red Cross Society, a meeting was held at the Birmingham University on December 5th, under the chairmanship of Professor Gilbert Barling. The object of the society is to supply voluntary aid to the sick and wounded during the time of warfare, and during the time of peace to ascertain how the necessary supplies may be obtained when the need shall arise for them. Apologies for non-attendance were read from the Marquis of Hertford, Sir Oliver Lodge, Mr. Neville Chamberlain, and Mrs. Joseph Chamberlain. The Chairman said that hitherto the work of the society had been small and imperfect owing to improper organisation. Although we were in no anxiety to be involved in warfare at the present time, we did not know when we might become involved in some important struggle, and it was necessary to form such an organisation, which would assist in securing aid for the sick. Mr. Antony A. Bowlby, C.M.G., F.R.C.S., surgeon to St. Bartholomew's Hospital, London, then addressed the meeting on Red Cross work. He said that this was the first meeting of the society that had been held out of London. On the proposition of Lieutenant-General Phelps it was decided that a branch of the British Red Cross Society be established. A committee of local ladies and gentlemen was formed, and the Marquis of Hertford was elected as president of the branch.

New Accident Hospital for Barry.

Mr. J. Spencer Low conducted a Local Government Board inquiry at Barry Dock on December 4th into an application by the Barry District Council for sanction to borrow £7,115 for a new town accident hospital at the junction of Tynewydd Road and Wyndham Street, Barry Dock. The Clerk said that there was great need for a suitable accident hospital at Barry. The present premises were not only inadequate and unsuitable, but defective from a hygienic point of view. The Commissioner asked how the medical men were appointed on the staff of the hospital, and was told that the Council appointed them. A rota for the year was drawn up, but not half the medical men of the town are on the staff now. The Inspector: So it is a life appointment?—Yes. (Laughter.) Does anyone cease to become a member of the staff?—Yes. Through death or any other causes?—Yes.

Alleged Illegal Operation at Bristol.

AT the Coroner's Court, Merchant Street, on the 5th, the City Coroner held an inquiry into the cause of the death of Kate Radford, a married woman, æt. 28, upon whom it is alleged an illegal operation was performed by a woman named Florence Cowle. The latter was arrested on November 25th at her home in City Road, and on the following day brought up at the Bristol Police Court on the above charge and remanded. The proceedings were watched on behalf of the police by Deputy Chief Constable Croker and Mr. F. P. Tyrell (from the Town Clerk's office), and Mr. F. E. Metcalfe for Mrs. Cowle (accused), who was present at the hearing.

VERDICT OF MURDER.

The jury announced the following decision:—"We unanimously agree with the medical evidence, that the death of Mrs. Radford was due to peritonitis and blood-poisoning, which we consider was brought on by a miscarriage caused by an illegal operation performed by Mrs. Cowle."—The Coroner: That is a verdict of murder?—The Foreman: Yes, sir.

Strike of Medical Students in Calcutta.

THE great bulk of the Bengali students in the Campbell Medical School, Calcutta, numbering about 160, went out on strike at the end of October. The alleged "grievances" leading to this action were of so flimsy a character that there can be little doubt that the young men have been acting under the inspiration of political agitators. A large hospital is attached to the school, and apparently it was thought that the patients would suffer from the absence of the students, but this has not been the case, owing to the existence of a large supernumerary staff and to the devoted labours of nurses, teachers, and others. The strikers seem to have anticipated that they could secure admission to the other medical colleges of the city, but they were refused at the Calcutta Medical School and at the College of Physicians and Surgeons. The few students who remained at the school have been subjected to great pressure to join the strikers, and some of them have been in such bodily fear that they have not ventured away from the hospital grounds. After the strike had lasted nearly a fortnight, Major J. C. Vaughan, I.M.S., the superintendent, issued a notification to the effect that, the time fixed for return to work having expired, he had decided, with the approval of Government, to close further negotiations with the students. He had already dismissed from the school thirteen ringleaders of the strike, and he had now to intimate that all those who had not resumed work by that date were held by their own act to have severed their connection with the school, and to have ceased to be students of the school. But as many who had absented themselves from their work had been induced to do so by evil outside influences, he did not wish to close the door entirely against them. Therefore students desiring re-admission must make application, and each case would be considered on its merits. No one would be admitted during the current year unless the circumstances seemed to warrant the exercise of clemency on his behalf, and unless there was reasonable chance of his completing the studies apportioned for the year.—*The Times.*

Medical Sickness and Accident Society.

The usual monthly meeting of the Executive Committee of the Medical Sickness, Annuity and Life Assurance Society, was held in London on 30th ult. There were present: Dr. de Havilland-Hall, in the chair, Drs. J. Brindley James, Frederick S. Palmer, J. W. Hunt, St. Clair B. Shadwell, F. J. Allan, M. G. Biggs, W. Knowsley Sibley, Walter Smith, M. Greenwood, J. B. Ball and Mr. J. F. Colyer. The record of the business is still good and since the beginning of the year a considerable addition has been made to the cash reserves. The sick claims have so far been moderate, but there are signs of an influenza epidemic, and if this becomes at all general it is certain to make its mark in this claim account of the Medical Sickness and Accident Society. The reserves which the Society now possesses have been made to cover risks of this description, and are ample for all purposes. Prospectuses and all particulars on application to Mr. F. Addiscott, Secretary, Medical Sickness and Accident Society, 33, Chancery Lane, London.

St. Thomas's Hospital, London

THE following have been selected as House Officers: Casualty Officers (from Jan. 1st, 1907).—(Senior) A. W. Hooker, M.B., B.S.Lond., M.R.C.S., L.R.C.P.; (Junior) J. H. Drew, M.B., B.S.Lond., M.R.C.S., L.R.C.P. Resident House Physicians.—H. C. Squires, M.A., M.B., B.Ch.Oxon., M.R.C.S., L.R.C.P.; A. N. Dickson, M.R.C.S., L.R.C.P.; M. A. Cassidy, M.A., M.B., B.C.Cantab., M.R.C.S., L.R.C.P.; W. O. Sankey, M.B., B.S.Lond., M.R.C.S., L.R.C.P. House Physicians to Out-Patients.—E. V. Dunkeley, M.B., B.S. Lond.; H. A. Philpot, B.A.Oxon., M.R.C.S., L.R.C.P.; C. E. Whitehead, B.A.Cantab., M.R.C.S., L.R.C.P.; H. G. Bennett, M.R.C.S., L.R.C.P. Resident House Surgeons.—R. J. H. Cox, M.B., B.S.Lond., M.R.C.S., L.R.C.P.; F. S. Hewett, B.A.Cantab., M.R.C.S., L.R.C.P.; A. B. Howitt, M.A., M.B., B.C.Cantab., M.R.C.S., L.R.C.P.; W. G. Howarth, M.A., M.B., B.C.Cantab., M.R.C.S., L.R.C.P. House Surgeons to Out-Patients.—C. M. Page, M.B., B.S.Lond., M.R.C.S., L.R.C.P.; S. G. MacDonald, M.A., M.B., B.C.Cantab., M.R.C.S., L.R.C.P.; H. B. Whitehouse, M.B., B.S.Lond., M.RC.S., L.R.C.P.; R. L. Gamlen, B.A.Cantab., M.R.C.S., L.R.C.P. Obstetric House Physicians.—(Senior) C. R. B. Eyre, M.R.C.S., L.R.C.P. (Junior).—A. C. H. Suhr, B.A.Cantab., M.R.C.S., L.R.C.P. Ophthalmic House Surgeons.—(Senior) H. E. Gotelée, M.R.C.S., L.R.C.P.; (Junior) C. W. A. Ward, M.R.C.S., L.R.C.P. Throat Department.—F. B. Treves, B.A.Cantab., M.R.C.S., L.R.C.P.; J. Wallace, B.A.Oxon., M.R.C.S., L.R.C.P. Skin.—G. M. Huggins, M.R.C.S., L.R.C.P.; S. L. Walker, M.R.C.S., L.R C.P. Ear.—E. L. Atkinson, M.R.C.S., L.R.C.P.; G. G. Butler, M.R.C.S., L.R.C.P.; H. A. Kisch, M.B., B.S.Lond., M.R.C.S., L.R.C.P. Dental.—H. W. Read, M.R.C.S., L.M.C.P. Children's Surgical—H. J. Nightingale, M.R.C.S., L.R.C.P. Electrical Dept. and X-Ray Dept.—H. A. Kisch, M.B., B.S.Lond., M.R.C.S., L.R.C.P.

University of London.

The following candidates have passed the M.B., B.S. Examination, with honours:—E. F. Finch (*b*), Univ. of Sheffield; R. A. Hendry (*b*, *e*), Uni. of Liverpool; C. A. Pannett (*B.Œc.*), St. Mary's Hosp. A. Pearson (*a*), Guy's Hosp.; G. F. Stebbing (*d*), Guy's Hosp.; D. C. Taylor (*d*), Univ. Coll.; W. H. Trethowan (*a*), Guy's Hosp.; E. Wragg (*b*), Guy's Hosp.

The following have also passed M.B., B.S. Examination:—W. Arnott, T. H. Barton, H. H. Bashford, A. W. Berry, J. S. Bookless, A. H. Bradley, Hilda M. Byles, H. J. Cates, I. R. Cook, I. J. Davies, C. H. Davis, S. W. Daw, J. B. Dawson, A. B. Edwards, W. H. A. Elliott, E. W. Gieson, L. F. Hurst, B. W. Jones. Edith A. Jones, H. A. Kisch, W. A. McEnery, P. F McEvedy, I. C. Maclean, A. T. Marshall, Dorothea C. Maude, C. A. L. Mayer, Sylvia May Moore, E. H. A. Pask, Eleanor W. Perkins, W. C. Pickering, A. Randle, E. F. Reeve, J. E. Robinson, W. O. Sankey, H. B. Scargill, W. L. Scott, Zilla Mary Scruby, J. E. Smith, Grace Maud Stagg, G. W. Sudlow, Bessie W. Symington, A. K. R. W. Taylor, Ida Clare Tengely, S. Upton, Margaret I. Waller, E. J. Wyler, G. P. Young, A. Zorab.

(*a*) Distinguished in Medicine.
(*b*) Distinguished in Pathology.
(*d*) Distinguished in Surgery.
(*e*) Distinguished in Midwifery and Diseases of Women.

University of Dublin—Chair of Surgery.

THE Board of Trinity College have appointed Edward Henry Taylor, M.D., to the Professorship of Surgery, vacated by Edward H. Bennett, M.D. Dr. Taylor has been acting as deputy for the Professor of Surgery since October, 1904.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT SURGICAL LITERATURE.

The Surgery of the Lung, with an Illustrative Case.—Fink (*Indian Med. Gazette*, November, 1906) discusses the symptoms and his treatment of a patient who was stabbed in the chest. A red mass, about the size of a man's hand, was found protruding between the ninth and tenth ribs, through a wound about three inches long in the mid-axillary line. On three or four occasions before admission to hospital a hissing sound had been heard during respiration. The protruding mass consisted of collapsed lung and pleura. Costal and visceral pleura were both torn. The parietal wound was firmly plugged by the protruding lung, which did not crepitate. Breathing was fairly quiet, but the patient complained of pain in the shoulder and upper part of the chest. On stretching the wound slightly with the finger air entered the pleural cavity with a hiss, and the patient complained of some pain. There was little hæmorrhage. The patient refused operation on the night of admission, and slept a few hours. Next morning the whole protruding mass of lung was ligatured by interrupted silk ligatures, and excised with a sharp scissors. The ligatured portion was returned into the pleural cavity. This procedure was accompanied by a slight rush of air, but did not cause the patient much discomfort. The whole operation was performed without an anæsthetic. The subsequent history was uneventful, the patient making an excellent recovery. The lung became normal to percussion and auscultation. The author draws attention to the following facts:—Though air had undoubtedly entered the pleural cavity, the patient had no dyspnœa. With such a large opening in the thoracic wall, one would have expected serious collapse of the lung; but such did not occur. On the contrary, a piece of the lung was pushed out of the thorax. The parietal wound became plugged, and thus more external air was prevented from entering the pleural cavity. The wounded part of the lung being outside the thorax, no air escaped from the lung into the pleural cavity. There were probably some adhesions between the parietal and viceral pleura at the time of the operation. The ligature applied to the protruding mass of lung bound the two pleural surfaces more securely together, and in this way the collapse of the lung was effectively prevented. S.

The Operative Treatment of Ulcer of the Stomach and its Chief Complications.—Mayo Robson (*Brit. Med. Journ.*, November 17th, 1906) states that on ample evidence we may accept the fact that at least one-third of all the cases of ulcer of the stomach treated medically ultimately succumb to the disease, or to one of its many complications, and that one-half or two-thirds of the cases that recover relapse. In the author's own experience alone in over 400 operations of various kinds the total mortality has been only a little over 3 per cent., and the patients completely relieved have been over 90 per cent. Ulcers may be classified into acute and chronic. In acute ulcer the treatment should at first be medical, and, above all things, it should be thorough. If after three months' careful feeding, at first on milk only, the patient is not free from digestive troubles, the question of surgical treatment should be seriously considered. In chronic or relapsing ulcers, if medical treatment has had a fair trial, yet non-relief or relapse after temporary freedom from symptoms occurs, surgical treatment ought to be urged. Surgical treatment may be direct, as in the excision of the ulcer, or indirect as gastro-enterostomy, pyloroplasty, etc. The author's experience of direct operations alone are unsatisfactory. The operation of excision of the ulcer-bearing area with the performance of an independent gastro-enterostomy will probably in the future be more frequently performed, especially as 59 per cent. of cases of cancer of the stomach give a history of chronic ulcer. Mayo Robson considers pyloroplasty and its modifications an unsatisfactory treatment compared with posterior gastro-jejunostomy. The ill effects, as regurgitant vomiting, said to follow the latter operation can probably all be avoided by correct technique. Death from asthenia is no longer a danger, as feeding can be begun immediately after operation. The danger of primary hæmorrhage is entirely avoided by continuous sutures embracing the margins of the openings between the two viscera. The only complication that perhaps is unavoidable is extremely rare, *i.e.*, peptic ulcer of the jejunum. The author thinks the condition will in future be avoided by making the opening sufficiently large, so that there can be no possibility of stasis. Also, by careful dieting, so as to thoroughly cure the hyperchlorhydria. The author's experience in perforation is that excision of the ulcer is not necessary to success, and that a folding-in of the edges of the rupture, with a careful application of a serous suture, and, if possible, an omental graft laid over it, gives the best results. Gastro-enterostomy performed at the same time, if the patient can stand the strain, has the following points decidedly in its favour:—(1) Other ulcers present at the time will probably be cured. (2) If a second ulcer is on the point of perforation, this will probably be prevented, as the tension and pressure on the stomach walls will be avoided. (3) More secure healing of the sutured ulcer is likely to occur. (4) The risk of hæmatemesis is diminished. (5) Saline aperients may be given early, and so secure more efficient drainage of the peritoneal cavity. (6) Earlier feeding is possible. Regarding hæmorrhage, general treatment is successful in arresting acute hæmatemesis in from 93 to 97 per cent. of all cases, therefore medical treatment should always have a fair trial in every case. Surgical treatment is direct and indirect. Mayo Robson is of opinion that the indirect method of posterior gastro-jejunostomy is usually an efficient means of treating this condition, and it is only under exceptional circumstances necessary to treat the ulcer directly, thus avoiding a possibly prolonged search for the bleeding vessel. In pyloric stenosis and obstructive dilatation it is generally agreed that gastro-jejunostomy is the procedure that should be followed, not only because it can be done with little risk, but also because the after results in these cases are extremely satisfactory. The treatment of gastric tetany is essentially surgical. Drainage of the stomach by gastro-enterostomy relieves the tetany, and at the same time cures the disease producing it, as in almost all cases there is a grave mechanical obstruction to the onward passage of the food. In hour-glass stomach it seems quite clear, according to statistics, that whether gastroplasty or gastrostomy be adopted for making a communication between the two stomach cavities, a gastro-enterostomy ought to form part of the operation in order that the ulceration giving rise to the disease may be cured. S.

The Modern Treatment of Intracapsular Fractures.—Hunt (*Medical Record*, November 3rd, 1906) reports three cases in which he used Maxwell's treatment. This comprises the old downward extension with adhesive straps, with side traction at the groin carrying a pull upwards, outwards, and forwards. This takes up the weight of the thigh, holds it opposite the point of fracture, and draws the capsule like a tight sleeve over the fragments, holding them in place. In Case I. the patient, a woman, was over 80 years old. Beside the fracture the patient had a troublesome cough, and commencing bed sores. She had a long and tedious illness, but in a few months made a good recovery,

and was about in four months. The leg is somewhat shorter than its fellow, but the patient walked without a limp, and is alive and well to-day. Case II. was a woman of 75. She had no trained nurse, and on account of living some way out of town, was seldom seen. Patient recovered without any limp, and with about an inch or less of shortening. Case III. was a woman 82 years of age. Maxwell's treatment was carried out for forty days, when the patient was allowed up. Some ankylosis of the knee-joint occurred, but subsequently disappeared, and the patient was able to get about without any limp, so that no one would suspect that she had injured her hip. S.

Congenital Distichiasis.—A. R. Brailey (*Trans. Opthal. Soc.*, 1906) reports a case of this rare condition, and summarises the cases already reported, as well as four unpublished cases. The case occurred in a healthy boy, æt. 14, who was suffering from what appeared to be ordinary chronic conjunctivitis, but on close examination it was found that this was due to the presence of many fine hairs which, arising from the posterior margin of the upper and lower lids, lay directly on the cornea. The lids and the natural cilia were quite normal. The accessory cilia formed a single closely-placed row of fine, delicate, almost colourless hairs half the length of the normal cilia, from which they were separated by the whole width of the inter-marginal space. These abnormal cilia seemed to grow from the meibomian glands, but on pathological examination it was found that the meibomian glands were quite absent, and their place taken by the follicles of the erring cilia. The only departure from the normal in the patient was the presence of two accessory bicuspid teeth in the right lower jaw. Kuhnt defines distichiasis as "a congenital condition in which the meibomian glands are absent, and their place taken by a row of accessory cilia with all their attributes." This definition is supported by the histological examination of Brailey's case. Brailey thinks the term distichiasis should be confined to this condition, and not applied to those cases which are really grades of trichiasis due to trachoma and allied disorders of the lids. He differentiates the conditions thus:—Distichiasis occurs in lids otherwise normal with the exception of absence of meibomian glands, whilst in trichiasis the whole lid is distorted, the new hairs spring up anywhere along the lid margin, and the sharp posterior margin of the lid is lost. Distichiasis is noticed in childhood, or about puberty—an age when trichiasis is seldom seen. M.

Tubercle of the Bulbar Conjunctiva.—W. I. Hancock (*Trans. Opthal. Soc.*, 1906) reports a case in a child, æt. 12. Two months before seen the patient was struck in the eye by a skipping rope. A fortnight later a small red patch was noticed which had grown rapidly. Beneath the corneal limbus was found a round, pinkish-red, firm nodule, with rough surface studded with fine yellow points. It measured 8 mm. and was adherent to the episclera, with much engorgement of the neighbouring conjunctival vessels. Right pre-auricular gland was enlarged, also right and left sub-maxillary glands to a slighter extent. No evidence of tubercle in the boy. The growth was removed by excision and scraping. It had penetrated the sclera, and the ciliary body was exposed, but by covering the wound by a large conjuctiva flap healing took place by first intention. Two months later the wound was soundly healed and free from redness, and vision, etc., were quite normal. The growth was typically tubercular, the tubercle bacillus being found in small numbers. M.

The Surgery of the Upper Abdomen.—In this article J. Boucher (*New York Med. Journal*, November 10) deals with gall stones, duodenal and gastric ulcers, the methods of diagnosis, and the appropriate treatment in each class of case. In gastric ulcer he discusses the important question, Which cases are medical and which cases are surgical? The dividing line cannot be drawn for some years to come. Many patients with the first attack without serious hæmorrhage, who can give up time, and who realise the importance of prolonged rest, will recover under medical treatment. The author thinks that the following types should be considered surgical:—1, Cases of relapsing acute hæmorrhage; 2, cases with persistent hæmorrhage, causing anæmia; 3, perforations; 4, recurrent ulcer, pure and simple, attended with dyspepsia and starvation; 5, pyloric obstruction; 6, adhesions following ulcer or independent of it; 7, scar contraction of the body of the stomach, giving hour-glass condition; 8, some cases of intractable dyspepsia originating in an ulcer, and for which the definite pathology is unknown.

The Preventive and Abortive Treatment of Mastoiditis.—W. Bryant (*Post Graduate*, November) writes this paper with the object of proving that prophylactic treatment is successful in preventing mastoiditis, and that abortive treatment, if commenced before the inflammation is far advanced, will, as a rule, obviate the necessity for a radical mastoid operation; he summarises his paper in the following way:—1. Orthopædics of the nose occupy a basic and important position in regard to prevention of mastoid inflammation. 2. Localised occlusion of the nasopharyngeal tract, and interference with the normal air currents of the head, are important predisposing causes of mastoiditis, and prophylaxis demands their correction. 3. Disturbance of the mucous membrane of the nasopharyngeal tract predisposes to mastoiditis and requires treatment. 4. Prophylaxis of mastoiditis in cases of chronic middle ear suppuration is accomplished by cure of the suppuration, which can be done before the involvement of the bone is extensive. 5. Abortive treatment will succeed in the vast majority of acute cases if commenced early. 6. Care of the middle ear inflammation, and Wilde's incision are the most important abortive procedures in mastoiditis. G.

The Prevention of Epididymitis.—W. Belfield writes (*New York Med. Journal*, November 24) an account of a method he has tried with success in four cases of gonorrhœal infection of the posterior urethra, in which the symptoms pointed to spread of infection along the vas deferens. The vas is exposed by a small incision half way up the scrotum, and fixed to the skin by a silkworm suture, which passes through the lumen of the duct. Each day a blunt hypodermic needle is passed into the canal, and an antiseptic solution syringed up into the ampulla and seminal vesicle. The author claims the following advantages for this method of treatment. The patient is saved from an attack of epididymitis, and the great danger of sterility which follows such an attack. If occlusion did by any chance occur, it would be in the vas, and could there be effectively dealt with by a plastic operation later on. It saves the patient much time, as the treatment does not require the patient staying in bed. The operation is done under local anæsthesia, and at its conclusion the patient can walk away to his business. G.

Fracture of the Anterior Superior Spine of the Ilium by Muscular Action.—Bebee reports a case (*New York Med. Journal*, November 17) in a boy of nineteen, who was running in a race, suddenly heard a snap, and felt a sharp pain in his right hip; it did not stop him from finishing the race. The anterior superior spine of the ilium on the right side was blunt, vague in outline, and tender to pressure, while the spine on the left side was sharp and prominent. Beneath the skin on the right side was a hard mass about an inch below the right spine. This mass moved freely, and produced no crepitus; a radiograph showed that a triangular piece of bone had been detached from the ilium. No bandages or treatment were used. In six weeks the patient could use his right leg as well as his left, the limp which followed the injury only lasting for about three weeks. Only four other cases of this kind have been recorded. Several cases have occurred of tearing off of the anterior inferior spine by the action of the rectus muscle. In the five cases in which the anterior superior spine has been detached all have occurred in boys of 17 or 19 years, and all have happened while the patient was running. It seems probable that the condition is really a separation of the epiphysis by the contraction of the sartorious muscle. Beyond rest in bed for a short time, the cases require no further treatment. G.

NOTICES TO CORRESPONDENTS, &c.

☞ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to 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 proofs.

CONTRIBUTORS are kindly requested to send their communications, if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions, the same rule applies as to office; these should be addressed to the Publisher.

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.

SUBSCRIPTIONS.

SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance.

PROVINCIAL.—You are, in our opinion, quite justified in taking the stand you propose with regard to Christmas festivities at your hospital. It is natural that nurses and convalescent patients should wish to have a "good time" at Christmas, but entertainments can be given in the board room or similar place, which are far more suitable for festivities than the wards, where there may be sick and even dying patients. No doubt there may be some hardship in individual cases, but careful management can generally secure every patient fit for enjoyment having some share in festivities, without hurting the feelings of relatives of the seriously ill ones.

HAYWARD'S HEATH.—There is a County Nursing Association, of which Miss Dyer is superintendent. It was founded some three or four years ago, and now covers 82 parishes and employs about 50 nurses.

THE BRITISH PHARMACOPŒIA.

F.R.C.P.—The report of the Committee of Reference in Pharmacy has just been presented to the Pharmacopœia Committee of the General Medical Council, and published. It contains recommendations with respect to many published criticisms of the 1898 B.P. You can obtain it from Spottiswoode and Co., Ltd., 54 Gracechurch Street, E.C. It will be found to contain over 300 recommendations for alteration in the preparation and assaying of drugs, all the result of a practical acquaintance with them, which pharmacists have better opportunity of obtaining than medical men.

AGNES.—We were very sorry to hear of the death of Sister Eliza, whose personality and work were well known to us. We are glad of the particulars you send us, but we have not space for such an article as you propose.

ANÆSTHETIC (Stafford).—We cannot say it accords with our experience that vomiting is more severe after ether than after chloroform. On the contrary, our inclination is to the opposite view. Different men's experiences differ, but we are not inclined to give way on the point.

D. S. (Clacton).—Thanks for your letter and for the information it contains. Please see comments in editorial columns.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, DECEMBER 12th.

HUNTERIAN SOCIETY (London Institution, Finsbury Circus, E.C.).—8.30 p.m.: Discussion on Toxæmic Insanity (opened by Dr. K. Will, Dr. W. Rawes, and Dr. B. Pierce).

DERMATOLOGICAL SOCIETY OF LONDON (11 Chandos Street, Cavendish Square, W.).—5.15 p.m.: Meeting.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—5 p.m. Bradshaw Lecture:—Mr. E. Owen: Cancer, its Treatment by Modern Methods.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. L. Cheatle: Clinique. (Surgical.) 5.15 p.m.: Lecture:—Mr. A. H. Tubby: Surgical Diseases of Children.

CENTRAL LONDON THROAT AND EAR HOSPITAL (Gray's Inn Road, W.C.).—5 p.m.: Demonstration:—Dr. D. Grant: Case Taking.

THURSDAY, DECEMBER 13th.

BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY (20 Hanover Square, W.).—5.15 a.m.: Adjourned General Meeting. 5.30 p.m.: Paper:—Dr. L. Williams: The Treatment of Gout by the Ingestion of Common-salt-containing Waters.

BRITISH GYNÆCOLOGICAL SOCIETY (20 Hanover Square, W.).—8 p.m.: Specimens will be shown by Dr. Aarons, Mr. J. F. Jordan, Dr. Swanton, and Mr. C. Ryall. Papers:—Dr. Hodgson: Cause of Fatal Collapse after Prolonged Abdominal Operations.—Dr. Macnaughton-Jones: Notes from the Clinics of Heidelberg and Freiburg.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street, Cavendish Square, W.).—8 p.m.: Card Specimens. 8.30 p.m.: Papers:—Mr. T. Collins: Adhesion of a Persistent Pupillary Membrane to the Cornea in the Eye of a Cat.—Mr. L. V. Cargill and Mr. S. Mayou: A Flat Sarcoma of the Choroid.—Mr. C. Shaw: Perforating Wound of the Globe with Total Destruction of the Iris and Retention of Vision.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.)—4 p.m.: Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m.: Lecture: Dr. T. W. Eden: The Value of Local Treatment in the Initial Stages of Puerperal Infection.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m.: Chesterfield Lecture:—Dr. M. Dockrell: Fungous Diseases of the Hair; III., Favus; IV., Leptothrix.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—5 p.m.: Lecture: Mr. R. M. Leslie: Opsonins.

FRIDAY, DECEMBER 14th.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8.30 p.m.: Papers:—Mr. B. G. A. Moynihan: The Mimicry of Malignant Disease in the Large Intestine.—Mr. J. P. Roughton: A Case of Rupture of the Diaphragm.—Mr. J. Berry: A Case of Traumatic Hernia through the Diaphragm.

EPIDEMIOLOGICAL SOCIETY (11 Chandos Street, Cavendish Square, W.).—8.30 p.m. Paper:—Dr. C. Brown: On the Distribution and Nature of Sprue, with Notes on the Pathology of Intestinal Dyscrasias.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.:—Mr. A. Lawson: Clinique. (Eye.)

THE SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN (11 Chandos Street, Cavendish Square, W.).—5 p.m.: Discussion on Rickets (opened by Mr. L. S. Dudgeon, Dr. F. J. Poynton, Dr. W. A. Milligan, Mr. H. Betham Robinson, Dr. Robert Hutchison).

Vacancies.

The Middlesex Hospital, W.—Medical Officer and Registrar. Salary £100 per annum, with board and residence. Applications to F. Clare Melhado, Secretary Superintendent.

Corporation of Sheffield.—Fever Hospitals.—Junior Assistant Medical Officer. Salary £120 per annum, with board, lodging, and washing. Applications to H. Sayer, Town Clerk, Town Clerk's Office, Town Hall, Sheffield.

Gloucester General Infirmary and the Gloucestershire Eye Institution.—House Surgeoncy. Salary £100 per annum, with residence, board, and washing. Applications immediately to the Secretary.

Plaistow Fever Hospital, London, E. Junior Assistant Medical Officer. Salary £100 per annum, with all found. Applications to the Medical Superintendent, Plaistow, London, E.

Cardiff Infirmary.—Resident Medical Officer. Salary £120 per annum, with board, washing, and apartments. Applications to Leonard D. Rea, Secretary and Gen. Supt.

Newcastle-upon-Tyne Union.—Assistant Medical Officer. Salary £150 per annum, with furnished apartments, rations, and washing. Applications to James Atkinson, Clerk to the Guardians, Union Offices, Pilgrim Street, Newcastle-upon-Tyne.

Brentford Union.—Medical Officer and Public Vaccinator. Salary £160 per annum. Applications to William Stephens, Clerk to the Guardians, Union Offices, Isleworth.

Appointments.

CUNLIFFE, E. N., M.D., Ch.B.Vict., M.R., B.S.Lond., Honorary Assistant Physician to the Manchester Royal Infirmary.

DAVIS, WILLIAM HENRY, L.R.C.P.Lond., M.R.C.S., Medical Officer for the Fourth District by the Devonport Board of Guardians.

GREEN, E. F. S., M.D.Glasg., House Physician at the Royal Infirmary, Manchester.

KEMBLE, A. C., L.R.C.P. and S.Edin., House Surgeon at the Eccles and Patricroft Hospital.

LANDER, CHARLES LLEWELLYN, B.Sc., M.B., B.S.Lond., L.R.C.P. Lond., M.R.C.S., Honorary Assistant Surgeon to the Royal Albert Hospital, Devonport.

LEAH, THOMAS NOY, M.B., B.S.Lond., L.R.C.P.Lond., M.R.C.S. Honorary Surgeon to the Royal Albert Hospital, Devonport.

MICHELL, JOHN CHARLES, M.R.C.S., L.S.A., Medical Officer and Public Vaccinator for the Fourth District by the Chipping Sodbury (Gloucestershire) Board of Guardians.

MOXON, F. H., M.B.Durh., Assistant House Surgeon at the Gloucester General Infirmary and Eye Institution.

REYNOLDS, ERNEST, M.D.Lond., Honorary Physician to the Royal Infirmary, Manchester.

ROLSTON, THOMAS RESTARICK, L.R.C.P.Lond., M.R.C.S., Surgeon to the Provident Dispensary in connexion with the Royal Albert Hospital, Devonport.

SANDFORD, GEORGE CALROW, M.D., C.M.Edin., Medical Officer to the Workhouse by the Devonport Board of Guardians.

SUTHERLAND, D. P., M.B., B.S.Lond, House Physician at the Royal Infirmary, Manchester.

Birth.

CRICHTON MILLER.—On Dec. 7th, at Villa Mary, San Remo, the wife of H. Crichton Miller, M.D. (San Remo and Aviemore, Inverness-shire), of a son.

Marriages.

ENNALS—ABBOTT.—On Dec. 6th, at Holy Trinity Church, Wallington, Surrey, Lieut. Charles Cutlack Ennals, R.N., son of Dr. C. T. Ennals, J.P., of Louth, Lincolnshire, to Rosalind Mary Abbott, elder daughter of Alfred Hillier Abbott, Beaumont, Wallington.

FOSTER—MALLAM.—On Dec. 8th, at S. Saviour's Church, Torquay, Edward Cecil Foster, M.R.C.S., L.R.C.P., of 179 Banbury Road, Oxford, eldest son of Edward Alexander Foster, I.S.O., to Agnes, third daughter of James Mallam, of Lamberhurst, Torquay.

MARTIN—HARLEY.—On Dec. 8th, at St. Stephen's Church, Philip Street, Sydney, New South Wales, Arthur Anderson Martin, M.D., Ch.B., F.R.C.S.Edin., Fitzherbert Street, Palmerston North, New Zealand, to Constance Margaret, only daughter of the late Alexander Harley, and of Mrs. Somerville Brown, Invertruim, Hassocks, Sussex.

Death.

WILLIS.—On Nov. 26th, at Asheville, North Carolina, U.S.A., Francis Willis, M.D., second son of the late Dr. Francis Willis, of Shillingford, Lincs., aged 73.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIII. WEDNESDAY, DECEMBER 19, 1906. No. 25

NOTES AND COMMENTS.

Infectivity of Consumption.

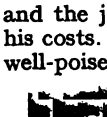
THE infectivity of tuberculosis appears to have got a strong hold on the imagination of people, and from the most utter laxity with regard to tubercular patients, they have now rushed to such an extreme that it is difficult to find a place where the poor consumptive is not taboo. The village of Eldwick is in a state of ferment at present because a sanatorium has been opened in its neighbourhood, to which the tubercular patients of the Bradford Board of Guardians and others are being sent. Why no steps were taken before is not clear, but now that the institution is open an indignation meeting has been held in which loud protests against this standing menace to the health of the village were made. The Chairman quoted the words of Dr. Munro, who promulgated the scheme, to the effect "that consumption was a most dangerous and insidious disease, and ought to be put on the list of notifiable diseases," and put a resolution that the village had a serious grievance, which was carried with only two dissentients, to wit, the medical officer and the matron of the sanatorium. It really seems time that another campaign should be started to teach people in what the danger of tuberculosis consists.

Sycosis or Impetigo.

IT is pretty safe to say that when lawyers get hold of a medical case they generally make a mess of it. True as this is of the High Court, the fact is still more evident in the County and other minor Courts. A case was tried at Exeter County Court last week before Judge Lush, in which a labourer sued a barber for shaving his chin so negligently that he contracted a disease, said by his doctor to be sycosis and by the defendant's to be impetigo. It was explained to the judge that if it were sycosis the fungus must have been inoculated by the barber's ministrations, whereas if it were impetigo it might have been contracted in other ways. Without referring to the question of diagnosis, which surely could have been settled in a few minutes by the microscope, it may be remarked that the point of the case really was whether the barber did or did not cause the disease through the use of dirty razors. His Honour thought otherwise. He laid down the new principle in English law that if a barber held out inducement to people to come to get shaved, he did not imply any warranty that it should be a safe shave. We can forgive the judge his want of knowledge of bacteriology, but not his ignorance of common law. The point has been made over and over again, that a man who undertakes to perform any service does undertake to exercise a reasonable amount of skill and care in its execution. We do not assert that the barber could have prevented the disease in this case, for we do not know all the circumstances, but he would certainly be liable if negligence could be proved.

Exhumation and a Will.

So many and so unjust are most of the accusations made against medical men, and so transparently unfair are most of the actions brought against them in the pursuit of their profession, that it is a peculiar pleasure to be able to congratulate a confrère when he is able to establish his reputation in a court of law. A short time ago we were able to felicitate Dr. Adams, of Buckhurst Hill, on the triumphant vindication of his professional acumen in what was known as the "Exhumation Case." The bias against Dr. Adams, however, displayed by Mr. Clarke in that instance showed itself again last week, when the former, as executor of the deceased lady's will, sought to propound it. Mr. Clarke contended that the will was not legally executed, and that the testatrix was of unsound mind. The amount of the estate was comparatively small, some £2,500, and after the payment of a legacy of £1,500 to a neighbouring church, and incidental expenses, the residuary estate was left to Dr. Adams. The latter amounted to about £200, and the natural man would think that sum a reasonably small amount for one friend to leave to an executor for his trouble. Mr. Clarke seemed to be disappointed that he was left out of the will, and the former insinuation against Dr. Adams having failed, he now took this form of inconveniencing him. Needless to say, the jury found for the will, and the judge very properly awarded Dr. Adams his costs. Would that justice were always equally well-poised in medical cases!



A "MOTOR-EXPERT" who was before Judge Stevenson in the Penrith County Court last week, or rather who should have been, put in an extraordinary medical certificate. This document announced that the defendant was "still out of danger, and unable to attend the Court." As the certificate was signed in the name of a registered practitioner it was impossible to ignore it, but we are glad to

note that the judge had sufficient regard for the general education of medical men to pronounce the certificate "obviously fraudulent." He adopted the wise course of granting a stay of execution, and telling the defendant that if no explanation was forthcoming he would be arrested. The latter, therefore, would seem not yet to be out of danger, in spite of his grandiloquent and "obviously fraudulent" certificate to the contrary.

LEADING ARTICLE.

THE LAY PRESS AND CANCER CURING.

In the *Pall Mall Gazette* last week appeared an article entitled "The Approaching Conquest of Cancer—Authoritative News," by C. W. Saleeby, M.D., F.R.C.S. Edin. It was written in boastful, flamboyant style, freely interspersed with references to reports from America, cables, and all sorts of exciting details about the writer's unique opportunities and private information, in spite of the opinion expressed in his opening sentence that what he had to say needed "no introduction or ornament." Now as this article was written by a medical man, and as it is precisely the most objectionable kind of article that can be written, namely, one booming in a lay newspaper a particular treatment still in the early stages of its consideration by the medical profession, we feel bound to criticise it closely. Dr. Saleeby started by speaking of a case of cancer cured by trypsin, which was published on November 24th in the *Medical Record*, a New York journal of deservedly high standing. Then he said he had heard another case was shortly to be recorded, and that Professor Morton, of New York, was about to send to the same journal a preliminary report on the treatment which was "much more sanguine" in its nature than had been anticipated. Dr. Saleeby then proceeded to plume himself on the fact that he wrote on this subject in "My Scientific Notes" on February 9th and on various later occasions that he "introduced it to all concerned in America," and that "if there is nothing to record from this country where Dr. Beard"—whom he mentioned as recommending the treatment—"lives and works, the fault is not his nor mine." Moreover, he adds, "since January 20th when Dr. Beard published his cases of cure in the mouse, not a case had been recorded here—*successful or unsuccessful.*" As to the accuracy of these statements it can only be said that Dr. Saleeby's other occupations must have been such as to place him entirely out of *rapport* with current medical work. We express no opinion on the value of trypsin—we have seen far too many remedies tried in inoperable cancer to make either sanguine or deprecatory comments on one that is still under trial and shows some encouragement in some directions—but it is common knowledge among all well-informed medical men that trypsin has been tried freely during the past year, and that several practitioners are pursuing their observations on it at the present moment. They owe nothing to Dr. Saleeby and his "Scientific Notes," having acquired their information where that writer has presumably failed to look for his, namely, in the current issues of medical periodicals and in recently-published books on the subject. Having committed himself in this egregious manner, Dr. Saleeby reproduces "without a moment's delay" Professor Morton's comments on the cases treated. These comments are very fairly worded, the strongest expression used by Professor Morton being that two cases were "cured to date," but as he had only been working with trypsin for a few months, such a statement has of course a purely tentative value, and Professor Morton, indeed, does not make any higher claim for it. It is otherwise with Dr. Saleeby. "I offer no vestige of an apology for the means I am taking to bring this matter before the public and the profession. . . ." "If an Englishman's work, bruited in America by me, can save despaired-of lives there, why, in the name of the Eternal, not here also? . . ." "My present business is to take advantage of my early knowledge for the sake of those whom it may serve." To use a lay paper for the purpose of publishing expressions of this kind is as improper as it is unbecoming, and in the next two numbers of the *Pall Mall* the hollowness and folly of the whole business was exposed by interviews with cancer hospital authorities, by whom it was revealed that trypsin had been tried both at the Middlesex Hospital and at the Cancer Hospital, and had proved disappointing in their hands.

Now the question of writing articles signed by medical men for the public press is always a delicate one. There is, we ourselves believe, a useful function for such articles to perform, namely that of educating people to take reasonable views of medical questions. But, if written, they should be most carefully worded, they should eschew anything in the nature of sensationalism, and they should show that the writer seeketh not his own. In a word, they should be the exact antithesis of the one we have mentioned. True, Dr. Saleeby says he does not practise, but that fact does not give him a free hand as regards professional traditions and professional ethics, so long as his name remains on the medical register. He says anyone who wishes to attack him is heartily welcome, and speaks of having been "snarled" at in America, with regard to his effusions on this subject. Well, we say that a writer who takes it upon himself to flout medical opinion by laying before the public a hope of cure from such a disease as cancer, on lines which have not the support and sanction of the profession, incurs a grave responsibility, and that when he is himself a medical man that responsibility is ten times heavier. The general result of such a course is to lead patients to dally with drugs till the time when the knife might cure has passed, and thus to conduce to their suffering and death. There are perfectly proper channels for bringing new facts and observations before the profession, and there are legitimate methods

by which new treatments may be tried. But when these safeguards are removed and immature conclusions are put before the public, cruel and bitter wrong may be done. A member of the medical profession who acts thus owes his profession an ample apology; that is, if he wishes to retain its respect.

NOTES ON CURRENT TOPICS.

Plum Pudding.

Raisins this year stand at famine prices, but that will not for a moment hinder the yearly output of many hundreds of tons of English plum pudding. All round the world will these dainty products travel, their solid frames compact with sweet nourishment and fragrant with odours of home and hearth. In these days of faked food and tinned horrors plum pudding forms a veritable sheet anchor for our shaken faith. Its genius is the very personification of purity and solidity. What say you of bread and flour and beer and suet and candied peel and currants and raisins and brandy and other good things all conglomerated into one fair round mass of unsurpassable comeliness? Were all the learned professors of the Royal Society to lay their heads together they could not hope to rival the simple beauty of form, the rich odour and colouring, the toothsomeness, the condensed nourishment and the digestibility that form part and parcel of this "speckled globe of savoury delights." Nor could science give us a more perfect method of sterilisation than that of boiling for hours and hours in a basin, so that twelve months later the pudding can be shaken out still sweet and wholesome, but a trifle mellower with age. Verily, the origin and progress of plum pudding mark the triumph of English brains in days when there was no science at hand to fill our minds with daily forebodings about our meat.

Violet Leaves and Cancer.

A London newspaper recently published the gist of an interview with an aged ironworker, who declared he had cured himself of cancer by the application of violet leaves. The journal in question, the *Morning Leader*, has assumed a great and serious responsibility in publishing statements of this kind. The man in question said in 1904 he had undergone four operations for cancer in the lip and throat. Some time ago he began the violet cure, drinking an infusion of the leaves and applying the leaves as a hot poultice. After six months his "cancer" was cured. Now, if that be the case—if there be no loophole of doubt as to the absolutely cancerous nature of the complaint, and that being proved the second point of "cure" be also established—then the *Morning Leader* has witnessed a miracle that has escaped the medical profession, in spite of its accumulated wealth of experience in such diseases, and of the incessant eagerness and high technical skill with which they are pursuing the subject day by day, year in and year out in laboratories, hospitals, and *post-mortem* rooms. we wonder did no gleam of scientific doubt penetrate the interviewer's brain when he sat talking to the "aged ironworker." We most of all wonder what was passing through the mind of the accomplished editor of a London newspaper when he permitted such sorry and misleading matter to slip into his columns.

Nine Miles of Protest.

On the 13th instant the Member for Anglesey presented the House of Commons with an enormous petition from members and supporters of the National Canine Defence League. The energy of the honourable gentleman was duly recognised by the cheers of the House when he stated that the document consisted of nine miles of parchment, weighing a quarter of a ton, and subscribed to by 400,000 signatories. The petitioners set forth that they were opposed to the vivisection of dogs, and prayed the House to pass a Dogs' Protection Bill, which should prevent those animals from being made the subject of experiment. Clearly it is simply from sentimental feelings that the exemption of the dog is demanded. At the present moment highly important observations are being made on cancer in dogs. Would the supporters of the petition, we wonder, if faced with this issue, venture to throw any obstacle in the way of probing to the depths one of the most fearful scourges of mankind? It may be wondered how many miles of parchment would be forthcoming in protest against, let us say, hunting carted deer, coursing rabbits, shooting trapped pigeons, plucking feathers from live birds, crimping living fish, or the countless cruelties that are every day committed in pandering to fashion, spurious sport, and other merely selfish pleasure and vanity. Yet any experiment performed upon a dog is an unselfish attempt to succour and aid suffering humanity—the highest and most transcendent of all conceivable human aims.

A Chance for the "Youngster."

We lately had the pleasure of reviewing Dr. Howard Kelly's Life of Walter Reed, the American Army Surgeon whose final glory it was to establish the specific relationship between the mosquito and yellow fever. The full effects of that discovery have not yet been reached, but already its enormous practical importance in the prevention of yellow fever has been demonstrated again and again. It is then only fitting that Reed's colleagues should have recognised his services to humanity by raising a memorial to him. At the end of last month a bronze tablet, suitably inscribed, was presented to the King's County Hospital, where Reed received his medical education, and a dinner was given in honour of the occasion. Dr. Howard Kelly was the speaker of the evening. and after a warm eulogy of the hero, he addressed some wise and straightforward remarks to his audience. Speaking of Reed's example and their enthusiasm for his memory, he said he wished his hearers to resolve to profit by them, and especially to seek to copy his spirit of uniform kindness and consideration for others, both rich and poor. To the physicians and surgeons he said that they should seek to train their students to take their places, and when they were ready, the older men should be ready to step aside and let the

youngsters have a chance. The advance of the young man should be looked on with affectionate interest and not with jealousy, and the young surgeon should be given every chance to operate. When his pupil was efficient, the teacher should be ready to resign part of his work to him, and with the leisure thus gained devote more time to study. He held it to be an iniquity for one man to hold so many hospital appointments as to keep him constantly busy. Which shows that in America as in England there is on the part of many medical men an acquisitiveness for hospital appointments which is beneficial neither to the profession nor to the public.

Tuberculous Pork as Food.

THE logic of the Britisher may be sound enough in the long run, but it is none the less apt to be extremely slow in reaching its goal. After much expostulation, for instance, it has been determined that portions only of the flesh of pigs may be sold for food when certain defined viscera, *e.g.*, the peritoneum or pleura, are infected with tuberculosis. On ordinary grounds the plain man in the street would ask, if tuberculosis pervade the whole body, what steps are taken to ascertain that the flesh of such animals is absolutely free from the taint of consumption. In the House of Commons various inconvenient questions were last week pressed upon the attention of the Local Government Board. It was stated that in Birmingham tubercular pigs were condemned and destroyed to the value of £100 a week. Mr. John Burns replied that the average destruction was much less than that mentioned, and he had no authority to compensate dealers. He practically admitted that the Birmingham market inspectors condemned animals previously passed by port officials. In answer to a further question the right honourable gentleman expressed a hope that he would shortly be able to bring a Bill before Parliament with the view of ensuring that the carcases of condemned pigs should not be sold for human consumption. This statement points to a solid, if somewhat belated, step forwards in a much-needed direction.

The Halifax Guardians and Medical Sweating.

An instructive object lesson as to the value of united action is presented to the medical profession by certain recent events at Halifax. The guardians of that town have lately given long and earnest consideration to a "serious crisis" that has arisen between their Hospitals Committee and the local medical profession as to the appointment of a resident Poor Law Officer. Founding our statements on a long report given in the *Halifax Guardian* of December 8th, we find that £160 salary was offered during the Boer War, when there was a dearth of medical men at home. After the war it was reduced to £150. What further reductions were made, if any, does not appear, but the next great pertinent fact is that on the recent retirement of a lady medical officer the post was advertised at £100 per annum. The guardians say that there were annual increments of £5 up to £120, but that fact was not mentioned in the advertisement. The attention of the British Medical Association and of its local branch was called to the reduction of salary. In the course of the resulting correspondence the branch maintained that £140 represented the lowest salary that should be accepted for the post. A "warning" was published in the *British Medical Journal* advising any intending applicants to write to the local secretary. The effect of this firm action upon the Halifax Board has been electric. They characterised the letter from the Association as "insulting and reprehensible." They disclaimed any intention of "sweating" the profession and claimed that their rate of pay compared favourably with that of most other unions. A labour member stood up in defence of the medical profession, whose attitude he regarded as reasonable and proper. He wanted to know, amongst other things, why it was "contrary to all notions of fair play" to warn doctors against taking a certain post while enquiries were being made. However, the mystery of the curtailed advertisement was not solved, and the guardians unanimously confirmed their Hospitals Committee report. We understand that they have since seen their way to modify their attitude. The incident shows the unspeakable value of medical unity and organisation.

The Recent G.M.C. Elections.

The recent election of four direct representatives for the General Medical Council offers various points of interest. The precise figures were officially reported as follows:—

Browne. Dr. Henry Langley	4,861
McManus, Dr. Leonard Strong	4,286
Latimer, Dr. Henry Arthur	4,002
Jackson, Mr. George	3,985
Brown, Mr. George	3,773
Smith, Mr. Joseph	2,489
Smith, Mr. Frederick John	2,013
Broadbent, Mr. George Harry	1,785
Renshaw, Dr. Charles Jeremiah	1,080
Rhodes, Dr. John Milson	855

The election is memorable as being the first held under the new regulation, whereby voting by ballot is established. The total number of voting papers issued was 24,659, against 23,473 in 1902. The total number of papers received back was 12,828 or 52.02, of those issued. Nine hundred and eleven letters were returned by the Dead Letter Office, and no less than 1,508 votes, or 12.61 per cent., were invalid owing to the non-compliance with clearly stated directions as to signature, fastening of envelopes, and so on. A more striking commentary upon the unbusiness-like methods of the medical profession could hardly be imagined. Two old and faithful servants of the profession have been dismissed from the Council in the persons of Messrs. George

Brown and Jackson. Dr. F. J. Smith is the only consultant on the list. Messrs. Broadbent, Renshaw and Rhodes appear to have secured mainly local support. In Scotland Dr. Bruce, after some twenty years' service, has been replaced by Dr. Norman Walker.

Carted Stag in a Labourer's Cottage.

The Surrey stag-hunt has witnessed many scenes of cold-blooded barbarity that might well send a thrill of horror through civilised society. The story of the chase of a deer a week ago is a standing disgrace to all engaged in so spurious a form of sport as that of hunting carted deer. On the occasion under notice a pack of hounds and huntsmen chased a deer that fled along the South-Eastern railway line, and narrowly escaped being cut to pieces by a passing train. Upon reaching the outskirts of Redhill she crossed and re-crossed the line several times; and eventually took refuge in the premises of the National Telephone Company. Being ousted thence she darted away and dropped fifteen or sixteen feet into a roadway. Leaping a high wall, the poor affrighted creature rushed into a labourer's kitchen, where she at last found pity and protection. This sort of thing may be considered a manly amusement for sportsmen and gentlemen, but we venture to say it would be roundly described as barbarous brutality and inhuman cruelty by the scientific men who as vivisectors are] branded as simply outside the pale of humanity. Now, let it be asked, if vivisection merits nine miles length of petition to the House of Commons, what length would be required to protest adequately against the naked and unabashed torture inflicted by the hunters of the carted deer ?

Resignation of Poor Law Medical Officer.

The official inquiry into the administration of the West Ham Board of Guardians has led to many unexpected results. Already one of the guardians has committed, and another has attempted, suicide, while others are on their trial for fraud, and a contractor is undergoing penal servitude. In the Infirmary a good deal of wastefulness and laxity was disclosed. The Local Government Board have requested Dr. E Vallance, the medical superintendent, to send in his resignation. Their reason is that the unsatisfactory state of affairs was largely due to the want of proper supervision by that officer, and "his failure to exercise the general administrative control, which is an essential requisite for his position." In a letter to the guardians the Local Government Board observes: "In view of this dereliction of duty, and his laxity in matters under his immediate control, such as the diet of patients and the large supply of alcohol, the Board have arrived at the conclusion, and they cannot properly allow him to retain office, and they have addressed to him a letter, a copy of which is enclosed, requiring him to place his resignation in the hands of the guardians." The guardians decided not to discuss the matter, and they directed the clerk to inform Dr. Vallance of the Local Government Board request.

"Improper Treatment."

It has not been long in coming. In an article last week we pointed out—not that much prescience was needed to do so—that if the jury's decision in the "Cardiff Surgeons" case were allowed to stand, the position of medical men with regard to their patients would be seriously compromised. Sitting last Wednesday, the Board of Management of the Cardifi Infirmary received a letter, in answer to an invitation from them, from an architect, Mr. Hiley, complaining of the treatment he had received as an out-patient at the Infirmary. This gentleman had been knocked down by a passing train some months previously near Ely, and had subsequently been treated for some time at the Infirmary. It is not in the least clear why an architect, presumably possessed of certain means, should have been treated at the Infirmary at all, and this point certainly seems to call for investigation. However, Mr. Hiley having accepted charity, proceeded to complain of his benefactors, as many people do when they get anything for nothing, and a sub-committee which inquired into the charges found, we understand from a report, that there was no foundation in them. Mr. Hiley, it is said, is now prepared to modify his views in the matter. We hope so, but we cannot be surprised at anything in the way of complaints as things now stand at Cardiff.

PERSONAL.

The managers of the Royal Hospital for Sick Children, Edinburgh, have appointed Dr. A. Dingwall Fordyce to be extra physician to that institution.

The only representative of the medical profession who has been awarded a medal by the Royal Society in 1906 is Professor Elias Metschnikoff.

The medical profession is not very strongly in evidence on the Council of the Royal Society under the new President, Lord Rayleigh. The three representatives are Professor David Perrier, M.D., Professor Ernest Starling, M.D., and Augustus Waller, M.D.

Pius X. has decided that Dr. Lapponi's successor shall be his old friend Professor Davenezia, of Venice, who was formerly Cardinal Sarto's physician.

Dr. Acland, having been appointed by the Royal Colleges of Physicians and Surgeons Official Visitor to the examinations of the Cairo Medical School, has left London for a few weeks in connection with the appointment.

The formal distribution of the Nobel prizes took place at Stockholm on December 10th to the following recipients:—Professor Moissan, of Paris (chemistry), Professor Thomson, of Cambridge (physics), Professor Golgi, of Pavia (medicine), and Professor Ramon y Cajal (medicine). All these received the prize diploma and a gold medal from the King in person. Professor Giosuè Carducci, of Bologna (literature), was absent, Count Caprara, the Italian Chargé d'Affaires, acting as his proxy. Each prize this year amounts to 191,480f. (£7,659).

A CLINICAL LECTURE
ON
DEFECTS IN DEVELOPMENT: THEIR SIGNIFICANCE. (a)

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GENTLEMEN,—If you go into the Surgical and Orthopædic Departments, you will see a large number of cases of congenital defect, of one kind and another, in gross form, mostly requiring surgical treatment: such cases, for instance, as clubfoot, cleft palate, harelip, possibly others of defect of the ear, congenital dislocation of the hip-joint, hemiplegia, and a number of cases of gross defect, which at once, and obviously, attract your attention. If you look at any large body of statistics of cases of this kind, the first thing that will strike you is that the larger proportion always falls upon males. I am not going to speak of those gross conditions, but of those cases of minor defects that you will see frequently among any group of children.

The proportion of children that have some condition of ill development is very large, and, as I have said, it falls mainly upon the males. In the course of an extended inquiry that I made personally in schools, when I had the opportunity of observing one hundred thousand cases during a series of years, and taking notes of them, this fact that I speak of came out very markedly. In putting the total results of that inquiry together, we found in looking over large numbers of children congregated in schools that, of the boys 8.7 per cent. showed some condition of defect in development, and of the girls 6.8 per cent.

Let me explain now what you should look for in a patient to satisfy yourself as to whether or not the conditions of development are up to the average or normal. Looking at this boy (a patient from the wards) we want to see whether he is a well-made boy or not, as apart from any question of medical diagnosis. The first thing to look at, and the most important of all, is the head. You will gain much information by the use of the tape-measure. The most important measurements to take are three. First of all, you should ascertain the circumference of the head—that is to say, the largest circumference that you can get. This boy is seven years old, and the circumference of his head is only a little over 20in. As to the normal circumference at birth, it should be about 11in.; at nine months, that is the time of dentition, when lactation should cease, it should be 17½in.; at the end of the first year 19in.; at seven years, when, in the generality of cases, school life has begun, 21in. This standard of measurement is higher than what one usually finds amongst hospital cases. Speaking for Buxton children's ward, nearly all the cases are small-headed. You may take another measurement of the head, the transverse, from the top of the meatus auditorius, over the vertex, to the top of the meatus on the other side. Another useful measurement is from the bridge of the nose, or the upper terminus of the nasal bones, to the occipital bridge. It is very important to watch in growth of the child not only the increase in the circumference of the head, but also the increase in the transverse measurement. There is very little difference between the transverse measurement and the occipito-frontal. In a well-made head the measurement from back to front should a little exceed the transverse measurement.

Having considered the question of the size and volume of the skull, let us turn our attention to other parts of the head. With regard to the face: the eye openings, or palpebral fissures should be sufficiently large, wide, and high, and long from side to side. Another item of normality about the palpebral fissures is that the axis of the two is in a straight line. We sometimes get a condition that is said by some to be a reversion to an earlier type of manhood, in which the transverse axis, instead of being horizontal, may slope outwards and downwards, or in other cases it may slope upwards; but the principal point, perhaps, is that of size.

It is important to observe the mouth and the nostrils. The principal point about the mouth is that it should be large enough. It is very common to have a small mouth in the male, and it is also very common to have a mouth which is kept constantly wide by grinning. A small mouth is frequently accompanied by a narrow and contracted palate, and by conditions causing obstruction to the nasopharynx predisposing to deafness.

Concerning the palate, what we like to see is a palate of good width, and the front of it well rounded. The common defect is that, instead of being well rounded in front, it is contracted laterally, and comes to a sharp angle in front, often spoken of as "V-shaped." This means that the anterior portion of the jaw on either side comes to the front in a sharp angle instead of a curve. This is a point of great importance, for, next to the condition of defective skull, the palate gives the greatest indication of the constitutional tendency of the individual. Professor Keith has gone over this matter very carefully with me, and has taken casts of various cases of defective palate, and analysed them. He concludes that in these cases of narrow and V-shaped palate, the condition is one of defective development in that portion of the upper jaw in which the milk teeth are produced, leaving out that portion in which we have the permanent teeth. This condition of narrow and contracted palate often goes along with nasal obstruction—such as enlarged turbinates, adenoids, and large tonsils and also, in female adults, with a form of dysmenorrhœa. So that, in adolescence, if you see a case of narrow and contracted palate, you should inquire as to whether there is any indication of stenosis of the os uteri giving rise to dysmenorrhœic symptoms.

The lower jaw should be in proportion to the upper. There are two common defects about the lower jaw; it may be too large when compared with the upper jaw, or it may be extremely small in comparison with it.

In regard to the nose, it is essential, for the purpose we have in view, to look separately at two parts of it—the bony nose, made up of the nasal bones, and supported inside by the septum, and the cartilaginous portion. A great deal of misunderstanding arises from not looking whether the defect is in the bony portion or in the cartilaginous portion of the nose. It is of comparatively little importance whether the cartilaginous portion is badly grown or not. A much more important question is, Are the nasal bones fully developed? In the infant the nasal bones are extremely small, and their development may be late, sometimes not beginning until the child is from one to two years of age. At seven years of age you may find the nasal bones still very short, making a small bridge to the nose, and giving it a very different appearance from one that is well developed. I have known many cases in which nasal bones have been very short up to seven and remaining so till between seven and ten years of age, although the cartilaginous portion has grown to its normal size. A boy, in such case, would have what is known as a tipped nose. It is not that the cartilaginous portion is bad, but it means deficient breathing.

(a) Delivered at the London Hospital, Oct. 31st, 1906.

We come next to the external ears. They very often have defects, but the defects are amongst those that fall in greater proportion on the boys than on the girls, being five or six times as frequent in the one case as in the other. What are the common defects of the external ear? First of all, the ears are generally symmetrically affected. There are criteria by which you can judge whether the ear is normal or not. First, are all the parts of the ear seen? Secondly, is the tissue of which the ear is composed healthy, normal tissue? This boy has got a well-formed helix. That is important. Thirdly, is the skin of the ear healthy? He has a nice, healthy ear. There are no little varicose or dilated veins about it; the skin looks of a normal colour, and you can pick it up, showing that it is not adherent to the cartilage. The tissue of the ear is normal in structure and size. A very common, and also very important, defect about the ear is an absence of the antihelix. This boy has got no antihelix. There you see a typical outstanding ear. If the antihelix is absent you get an outstanding ear. An outstanding ear is apt to be defective both in structure and tissue. The antihelix may be absent on one side or the other, that does not affect the hearing; an outstanding ear, without an antihelix, is often very good for collecting sound. It is said that in the advancement of man, in the process of evolution, things have gone on for the best; but let me point out that, amongst the lower animals, the donkey has not got an antihelix; its ears stand out, and are much better organs for collecting sound than the human ear.

Those, then, are some points of interest as indications of defective development.

The hand should also be examined. The fingers may be too long or too short, or there may be webbing of the fingers, or an excess of subcutaneous tissue on the palm of the hand, or an abnormality in the palmar markings. In some cases of defective development you find the marks which are totally different from those on the hands of ordinary people. Professor Keith has had impressions taken on paper of some of those markings on the hand, in cases of defective development, and analysed them, and shown that sometimes they correspond with those of lower animals.

There is a defect, called the epicanthis, which is not uncommonly found in the face, and consists of a vertical fold of skin projecting in front of the canthis in the inner portion of the eye openings. This is a defect of the Anglo-Saxon race, and a great deal has been said about this. The epicanthis is one of those defects which, in many cases, disappear before adolescence; many a child that has had epicanthis at five years of age has lost all trace of it when old enough to go into society.

Turning our attention once more to the ears, you may sometimes find just below the pinna a little cartilaginous growth. This appears usually on one side only, and is homologous to a supernumerary ear. This is important, because it may show a great tendency to grow rapidly.

I want next to speak of the significance of these minor indications of subnormal development. I pointed out to you that there are a large number of cases which show some point of subnormal development; but do not go away with the impression that, because there is some point in development below the normal, therefore the child is a defective one. I only say that the defect is worth noticing. Let us compare those individuals who have some condition of defective development with those who are perfectly normal. Taking the cases that had some of these conditions of defective development, we found, on further examination, that 22 per cent. of the boys were thin and pale, and delicate. Taking similar cases among the girls, 32 per cent. of them were pale, thin, delicate children. If you are dealing with children who are pale, thin and delicate, and yet have no condition of disease, you will find that a large number of them are cases such as I have been speaking of to-day, cases which show that their bodily growth has been imperfect in certain features. This law applies much more to girls than boys. A boy, with some condition of defective development, may go on in fairly good health, but a girl is much more likely to become thin, pale, and delicate, and then anæmic. These girls also tend to develop abnormal nerve signs, to fall into a condition of anæmic low nutrition, nervousness, and mental dulness, until they get into those grave conditions frequently seen in young womanhood, namely hysteria, or neurasthenia. I told you just now that, of the cases we examined that had some defect in development, 22 per cent. of the boys, and 32 per cent. of the girls were thin and pale and delicate. The percentage of boys suffering from irregularities of the nervous system was 36, and that of the girls 35, or almost the same. As to the condition of dulness, the percentage was the same in each case, namely, 31 per cent.

Perhaps an active, first-class "M.A." mistress of some girls' high school says, "The girls are as good as the boys, and a little better; they can work, and stay on at school, and matriculate." But, if you are practising in that town, you will have a great many more children patients delicate, and pale, and thin, and falling into conditions of ill-health among the girls than among the boys. That mistress is speaking of her girls on the average, and she says they can work well. True, but what about the percentage of her girls—about 6 per cent.—who have some condition of defective development? They would be known to you. And when the question is raised, concerning some girl, "Is she strong enough for a 'hare and hounds' race on Saturday afternoon?" her mother says, "She is not strong enough!" If it is one of those cases that are not perfectly good in those points of development that we spoke of, then there at once is a reason for being cautious. With regard to a high school, if you take a list of all those who present some condition of defective development, and then ascertain how many of the children left in the school show signs of delicate health, you will not find more than one to two per cent. But if you look at those on your list, those who have some condition of defective development, about one-third of them will betray a low state of health—they will look thin, or nervous, or dull, or anæmic. I think, therefore, you will recognise the importance of the practical points that I am speaking of.

I have a point to impress on you. Of the children that come into our medical wards we scarcely find any that are free from defect. The commonest defect is small head. Other defects that I have mentioned are also frequent. Children come in with a diagnosis of "marasmus." If the case is one of "rickets," it will be admitted as such. The large number of cases in Buxton Ward mostly show some condition of defective development, usually a condition of small head. It is those children who have some imperfect development from birth that tend to fall into a condition of low nutrition, bronchopneumonia, and other diseases which fill the wards.

Taking it that all the children in Buxton Ward are defective, let us look at the admissions during last year. There were 265 boys and 228 girls admitted into the ward during that time. I venture to say that the cause is not that those who admit patients into the hospital have any special desire that these should be boys, there is no question of male or female beds in Buxton Ward; it must therefore be a question of demand, and more males than females come in. Of the boys, 67 died during the year, and of the girls 65, representing a percentage of 25 and 30 respectively. We are looking then at the mortality of what may be termed a selected body of children with some degree of imperfect development, and you see that the percentage of deaths among the females is much greater than among the males. Bear that in mind. Looking at school life we find that, of those who have defective development, the tendency to become thin, and pale, and delicate falls greater upon the girls than on the boys. And so, in Buxton Ward, where all the children patients have some defect in development, you find that the tendency to death falls much more on the girls than on the boys.

As to the birth-rate, a larger number of male infants are born than female. At the end of the first twelve months of age, the number of female babies exceeds that of the number of male babies. The infant mor-

tality, of which we hear so much, and which is so exceedingly important, is, to a great extent, a matter of deaths amongst the males, because there are born so many more male infants with conditions of imperfect development. If a child has died during the first year of life, it is certified as a male or female; but for our present purpose the great question is, Was it a normally made child, had it a fairly developed head, and a sufficiently good brain inside? Though a larger number of males are born than females, yet owing to the much higher proportion of cases of defective development amongst males, the mortality that marks the latter leaves a considerable surplus of females in adult life. Not only in adolescence are there more women than men, but the women have had the best of it in infancy in having been better born, and, moreover, they live, on an average, some three or four years longer than men; that fact is borne out by the census reports. There is a very large preponderance of females, and a female life costs much more in providing for annuities than a male life. A thousand pounds utilised for the annuity maintenance of a man over sixty years of age would bring about £4 10s. per cent.; the same sum of money invested for the benefit of an old lady would not bring more than £3 10s. per cent., because she will probably live so much longer.

I have brought before you some points which I think it is of very great importance that you should watch while you are at the hospital, and I am sure they will become matters of considerable interest and importance in practice when you take charge of family interests yourselves. They will enable you, among other things, to make a better selection of those children who are delicate and those who are not delicate. Amongst the delicate class of children I include those who, though they do not suffer from any particular pathological condition affecting any one organ, yet, nevertheless, often have headaches, or feel tired, or get a little pale, or fall off a little in their appetite—trifling things which a mother notices, but which do not very much affect their future condition of health. A child in any of these conditions is delicate, in a sense, but often enjoys really good health.

NOTE.—*A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week's issue will be by Professor F. Lejars, M.D., of the Faculty of Medicine, Paris, on "The Differential Diagnosis of Typhoid Fever and Appendicitis."*

ORIGINAL PAPERS.

THE TREATMENT OF BRONCHIECTASIS.

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THE problem met with when we come to consider the treatment of bronchiectasis is unique in therapeutics.

At first sight it is apparently a condition eminently suited to surgical measures, namely, the presence in a viscus of numerous cavities filled with a fœtid secretion which has difficulty in escaping. And yet when the statistics are examined it is found that in the majority of cases surgery has failed utterly.

The indications for treatment, as tabulated by Dr. Ewart, are as follows:—

1. Emptying of the cavities.
2. Relief of the fœtor.
3. Reduction of catarrh.
4. Protection of membrane from further inhibition.
5. Diminution in size of dilatations.
6. Improvement of respiratory functions in general.

And it will be well to consider at once why surgical methods have failed in this instance, and to see if the results obtained hold out any hope that these methods may be successful in the future.

Trzebiski published a series of cases in 1892 showing that, with 12 operations for bronchiectasis, he had no complete recoveries, 8 deaths, 3 lost sight of, 1 so far doubtful.

In the same year Hofmokl's statistics were almost as hopeless; out of 14 operations he had only 2 complete recoveries.

And an examination of specimens of bronchiectatic lungs shows why this should be the case. It is not one large cavity, or even a series of communicating cavities, that has to be dealt with, but a number of isolated cavities burrowing throughout the lung, each being a focus for toxic absorption, and each unaffected by the cure of its neighbours.

The few successful cases are those in which the symptoms have been almost entirely due to one large cavity. If this is accessible, then operation is desirable, and a fortunate ending may be looked for. But in the majority of cases, with numerous burrowing cavities, operation holds out little hope of cure, although sometimes an improvement may be obtained by draining one, or even two, of the largest collections.

As regards the technique of such operations, it is generally agreed that it is best to make a very large opening into the chest wall, having previously localised the affected area with an exploring syringe. Then if adhesions have not been found between the two layers of the pleura so as to shut off the field of operation from the general pleural cavity, it is absolutely necessary to postpone the remainder of the operation. In the meantime, formation of the necessary adhesions is ensured by incising the parietal pleura and suturing the two layers together, as advised by Réclus. After five days or so the second stage may be proceeded with. It has been shown by results that otherwise empyema and pyopneumothorax are very liable to follow.

The actual incision of the lung tissue should be made with a Paquelin cautery, heated to a dull red. This seals most of the blood-vessels as it divides them, and prevents hæmorrhage that tends to be very serious, and possibly fatal. The draining of the cavity is then carried out by soft rubber tubes, but it is a point of great importance to note how emphatically the authorities on this operation protest against irrigation, several cases having been reported in which pneumonia resulted from such a procedure.

A consideration of the surgery of bronchiectasis, then, leads to the conclusion that unless the symptoms are very urgent, and at the same time undoubtedly due in the main to some one large and accessible cavity, less radical means must be relied on for the alleviation of the disease. Such measures may be classified into those tending to empty the cavities, those tending to reduce the fœtor, and those tending to repair the damaged bronchi.

Many patients soon find out that they can get rid of large quantities of bronchiectatic secretions by assuming certain postures. And the position from which the greatest relief will be obtained depends upon the situation of the cavity or cavities. A considerable number find that by assuming an inclined position, with the head and chest lower than the feet, the outflow freely gravitates out of the sacculations.

These postural methods should be practised as a routine, and combined with strong expectorant treatment. And, moreover, every few days further relief can be given by the administration of an emetic. In these ways the cavities are regularly emptied, and washed out by a stream of watery mucus.

But as the more severe symptoms, such as pyrexia, rigors, cachexia, and so on, are due to absorption of tissues resulting from microbic activity in the cavity contents, it is even of more importance to make the secretions aseptic than to ensure their expectoration.

Formerly the chief attention was paid to the fœtor, but it is obvious that measures removing the fœtor without being anti-microbic merely beg the question. If the cavities can be freed from "septic" organisms, the fœtor will cease as a consequence, and so it is necessary to find some means by which antiseptic substances can be introduced to the fœtid collections.

Many methods have been tested for this purpose,

inhalations, sprays, intratracheal injections and drugs by the mouth having in turn had their supporters. The difficulty has been to get the anti-microbic agent into the depth of the lung in sufficient quantities to influence the large fœtid cavities that exist there.

Simple inhalations from a jug of vapour impregnated with one of the volatile antiseptic oils may affect the superficial layers of secretions, but utterly fail to disinfect the greater bulk thereof. Now, any real good that is done by this method results rather from the product of cough and expectoration than from any anticipated local influence. These remarks apply equally to methods in which inhalation takes place through a dry sponge steeped in the deodorant mixture, on the principle of Yeo's inhaler. It is possible that inhalations given by a spray may be somewhat more adequate than the former, and both the steam spray and varieties of "nebulisers" have been extensively used. In the one instance large quantities of drugs can be used, but there are great disadvantages inseparable from the use of steam; in the other hand, an "atomiser" so finely sub-divides the oil globules that the actual supply of drug to the patient is very greatly limited.

This method of internal administration of antiseptic drugs fails, however, for although fully worked into the bronchial secretions, they do not reach the chief seat of sepsis, as the mucous membrane lining the bronchiectatic dilatations is so disorganised as to be incapable of physiological action. So that each of the antiseptic agents stops at the point where it is most urgently needed. A list of the drugs so used includes the balsams, copaiba, terebene, tar, oleoresins, and many essential oils, thymol, guaiacol, eucalyptol and creosote. On the Continent myrtol has been used by some physicians, and reported on favourably. Capsules containing these drugs should be taken frequently throughout the day, and by persistent action will undoubtedly relieve the fœtor to some extent.

However, although the above methods fail to do much good, it has been shown latterly that a more thorough application of the same principle will produce remarkable results.

Such are attained by the creosote method introduced by Dr. Chaplin, and to a less degree by Sehrwald's intratracheal irrigation method, and by Poore's saturation of the system with the volatile constituents of garlic.

By continued administration of garlic until the odour was permanent in the breath, very great alleviation of the fœtor and a diminution of discharge has been obtained. The remedy should be taken with meals, so as to minimise the inconvenience to the patient. The active essential oil of this plant contains sulphide of allyl, which is probably the active agent, and oil of allyl may be given in half to three minim capsules, three times a day. But excellent as the results obtained have been, this method does not bring about an emptying of the cavities, and so can produce no permanent benefit.

Intratracheal injections have been frequently used with success, but the disadvantages of such a method are numerous and obvious.

Usually one drachm of a mixture containing ten parts menthol and two parts guaiacol and 88 parts olive oil was injected through the glottis by a hypodermic syringe; the disinfectants reached the lungs through the medium of the trachea to varying extent. In this case also the method does not assist the emptying of the cavities, although it may give great temporary relief to the patient.

By far the most successful of these more thorough methods is Dr. Chaplin's plan of getting the patient to inhale an atmosphere permeated with creosote vapour to an extent which causes violent coughing and consequent expectoration of large quantities of secretion. At the same time, the creosote must be present in sufficient quantity to adequately disinfect the emptied cavities.

To attain both these ends a high degree of concentration is required, so that the inhalations can be borne only for a short time at first. Moreover, the vapour is extremely irritating to the conjunctival and nasal mucous membrane, so that means have to be taken to protect these parts, if the treatment is to be borne with any degree of comfort. In hospitals, when this method is made use of, a special inhalation chamber is prepared; it should be small, and as air-tight as possible. The creosote is vaporised from a metallic evaporating dish, which should have some stable support, otherwise a conflagration may ensue.

At first the patient can only bear a few minutes' exposure to the atmosphere of such a chamber, even when his eyes are protected by goggles and his nostrils plugged with cotton wool. But in a short time the process is got used to, and an hour's inhalation can be borne daily.

The cough produced is exceedingly efficacious in rapidly clearing the cavities of the most tenacious secretion, which at the same time is possessed of a horrible fœtor. Less spontaneous expectorations occur each morning as improvement results, and in about five or six weeks' time the cavities are cleared and disinfected, so that the final stage of recovery can proceed, and consists in the gradual contraction of the sacculations.

Numerous successful results have been published since the introduction of this method. The author has seen several instances of remarkable improvement following creosote inhalations at the Brompton Hospital.

Dr. Doble published a full account of one such case in the "British Medical Journal" some ten years ago (June, 1896), in which the course of disease and the effect of creosote inhalations were very clearly shown.

The patient was a man aged forty years, whose chief symptoms were progressive emaciation, paroxysmal cough, expectoration of fœtid sputum, sweating, languor, and an irregularly remittent pyrexia. It is noteworthy that with regard to physical signs Dr. Doble wrote:—Physical examination of the chest elicited no very definite signs beyond some coarse crepitations, which were usually to be heard at various parts of the lungs." He diagnosed the case as one of long-standing atrophic bronchiectasis, and began the treatment with inhalations of eucalyptus oil (dr. ss. to the inhaler) twice a day. Potassium iodide and terebene were given internally. But no improvement followed, and it was decided to try Chaplin's creosote method. This was carried out in accordance with the description already given, and at first the patient could only stand ten minutes in the chamber, owing to nausea and violent cough. However, he got used to it in a few days, and inhaled the concentrated vapour one hour daily for three weeks. Improvement took place from the very first, and after the first short inhalation even the cough was improved, and the temperature, which had been rising, and had reached 101.4 deg., began to fall. At the end of nine days there was no pyrexia, and after twenty-one days the treatment was discontinued, the patient being well. There was no subsequent return of symptoms.

Results as brilliant as this compelled a universal trial, and at the present time there is no doubt but that the creosote inhalations should be the routine treatment for every case of bronchiectasis. Unfortunately, there are a few cases that do not improve as much as is desired when so treated, and for these the other methods that have been described must be tried.

Necessary adjuncts to all these methods of treatment are the mechanical hygiene of respiration and climatic influence. Certain dry and stimulating climates have been found to greatly benefit the catarrh and the unhealthy mucous membrane.

Such are to be found nearest to this country along the Mediterranean coasts, and further afield in South Africa, California, and in some of the West Indian Islands.

But as the home treatment is now so much more efficacious than formerly, there is not the same need to rely on these especial sites, and many patients are sufficiently benefited by residence at one of our home resorts. In some instances the dry, cold atmosphere of the Alps is to be recommended in the winter months.

Hygienic measures ought not to be neglected, and the convalescent should continually practise inspiratory exercises and undergo a course of massage and passive movements applied to the abdominal and thoracic muscles. Such exercise will tend to promote the contraction of the sacculations and the general improvement of the respiratory functions.

In conclusion, it may be said that even the worst cases offer hope of improvement when systematically treated on the above lines, and, at all events, great relief can be given to the distressing symptoms; moreover, that in a minority of exceptional cases operation offers the greatest chance for recovery, and in a few well-chosen cases has produced excellent results.

THE PREVENTIVE TREATMENT OF NON-SPECIFIC DISEASES.

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WE must bear in mind that all parts of the organism are intimately connected for good or for evil in the living body. The sum of vital energy at the disposal of the individual is not unlimited, and there are moments in his existence when this has to be concentrated on one particular spot, as in combating infection or establishing a new function. In the young infant digestion is the principal function, and under ordinary circumstances matters go on smoothly until a demand is made on the fund of vital energy by some phase of evolution—teething, for instance. Provision must be made for this fresh demand, and if this be not done serious constitutional disturbance may accrue. Most of the accidents of dentition are due to over-alimentation, either comparative or absolute. The same remark applies to the establishment of puberty in the young girl. Here we must impose a large measure of repose, muscular, cerebral, and even digestive. At periods of rapid growth, it is true, a liberal supply of food is in a certain measure legitimate, but it will be all the more efficacious if associated with a reduced expenditure of energy. The menstrual function is throughout life a critical period. It comprises a salutary depletion, but it places the woman temporarily in a state of morbid imminence, and if the period be postponed by the necessity of concentrating the vital energy on a threatened point—lungs, liver, or what not—the woman will only recover complete equilibrium four weeks later, when the next period supervenes. Repose is therefore always indicated at the menstrual period.

At the menopause the suppression of a function entails the necessity for a modification of nutrition, and if the woman fails to conform to this requirement, nature will set up a supplementary emunctory, such as rheumatism, or bronchitis, or interstitial nephritis, or she may become a chronic dyspeptic.

The conclusion to be drawn from the study of the state of morbid imminence (see "Predisposition to Disease," MEDICAL PRESS AND CIRCULAR, October 10th, 1906, p. 385) is that all non-specific diseases are fundamentally identical—*i.e.*, they owe their existence to some change in the abdominal functions. In the complex human organism this change may be primary or secondary to a shortcoming on the part of the nervous system. It follows that a mild acute disease is often a fortunate circumstance, provided it be completely recovered from. It constrains its victims to repose and a healthful regimen, which arrest the morbid process, as is seen in the longevity of persons subject to migraine. Conversely it is by no means uncommon to see patients affected with chronic affections, and suitably treated, escape serious acute diseases, thanks to the rest and regimen which they are constrained to adopt. Most non-specific maladies can be avoided by timely recourse to rest and dieting. These two must always be associated, because rest facilitates digestion. The practice of resting after a meal which we inculcate on our dyspeptic patients is of unquestionable value. When we rest the voluntary centres, the sympathetic system can dispose of a comparatively larger amount of nervous energy for functional purposes. On the other hand, we cannot subject a patient or a person threatened with disease to a reduction of diet unless at the same time we insist upon repose—in other words, he must economise his strength.

The repose must be double in that it must ensure rest for the diseased organ, as well as of the whole organism, in order to liberate as much nervous energy as possible to fight the common enemy. Local affections tend to become general or to get worse if our energies are expended externally. Thus comparative repose should be insisted upon even in such affections as whitlow, zona, or even slight attacks of bronchitis, under penalty of the risk of aggravation or complications. For the principles that govern the preventive treatment of non-specific diseases are the same that must be applied when we desire to avert complications. It is good practice to be severe at the onset of even the most trivial maladies, and a rigid dietetic treatment is the best means at our disposal to curtail the duration of the attack.

The regimen must be a restricted or lessened one. It is always desirable to throw the least possible burden on digestion at the onset of an infection, whether grave or slight. In short but acute maladies, such as pneumonia, though it may be well to keep up the patient's strength by liquids, it is wrong to attempt feeding, properly so-called.

Absolute deprivation of food, and even liquids, is necessary in acute affections of the digestive tract, infantile enteritis, appendicitis hepatic colic, etc. Protracted liquid diet entails recourse to injections of serum, but the diet is itself an excellent preventive means. The child will never have grave enteritis or broncho-pneumonia or articular rheumatism if the patient has been subjected early enough and long enough to repose and diet. In every case the treatment should be strictly applied from the onset. Moreover, to avert recurrence, it is well to enrich the diet very gradually. The gradation of diet is the same in all diseases; at first diluted milk, or milk and egg; then pure milk and soups; then semi-solid foods, creams, purées, and lightly-boiled eggs. On the whole, abstinence from salt is a good thing in acute diseases. The food should be given in small quantities, frequently repeated.

These simple principles of hygiene are, unfortunately, unknown to many mothers of families and nurses; yet it is in early childhood that their efficacy is most clearly demonstrated, and it is at this age that negligence in this respect has the most disastrous consequences. In the newly-born, in a state of morbid imminence, rest is inadequate and illusory. The only prophylactic means at our disposal is functional rest. We cannot too strongly proclaim that the most important factor in determining the present high rate of mortality among the very young is, along with the too early administration of solid food, giving too much food.

It may safely be asserted that the majority of text-books advise far too large doses for the artificial feeding of infants. We do not recognise what a small quantity of cow's milk suffices to nourish an infant provided it be diluted with boiled sweetened water. Many infants twelve months of age do better on a pint and a half of milk diluted with half a pint of sweetened water than on a quart of pure milk. Between six and nine months a pint of milk is usually sufficient, provided it be diluted with a third of its volume of water. Between the third and fifth months the milk should be diluted with half its bulk of water, and given in fractional doses of one half to one pint. Infants under two months should not exceed half a pint, and the milk should be diluted with more than its volume of water—indeed, to begin with, twice its volume. These are merely general indications, for in every case we must be guided by the weight chart and the appearance of the stools. It is undesirable that a child should grow too quickly or get too big for its age.

The daily allowance of milk may be increased by about a teaspoonful every second day, so that by the end of the first year we shall have reached close upon two pints. For children over a year two pints is a maximum, and is not necessarily the proper quantity. The great point to be insisted upon is that when a child seems to be hungry, when it coughs, whenever the stools have too pronounced an odour, whenever it is in the least indisposed in any way, the fault lies in the direction of over-feeding. We must go back on our steps and very gradually re-increase the allowance. Even if over-feeding be not at fault, it behoves us, in presence of dentition troubles, to put the child on half rations. The treatment of the morbid state is the same as that of morbid imminence, and we must always commence by rest and diet.

In adolescents the treatment of the state of morbid imminence is somewhat different. Here muscular and cerebral repose is the fundamental requirement. Diet is only of use in so far as it is associated with rest. The regimen must be curtailed to begin with, then slowly augmented. Super-alimentation is only justifiable in growing lads on condition that it is preceded by a period of rest. We too often overlook the fact that it is contrary to common-sense to overfeed a patient or a threatened subject without insisting upon, at any rate, comparative repose. Too zealous and too hasty overfeeding is badly borne by many of these subjects.

The same remark applies to adults. Although we have to allow for the wear and tear of the struggle for life, we shall be doing good service to our patients if we insist upon an adequate cessation of professional work whenever the general health is below par.

At the change of life, and in old age, moderation becomes all the more necessary, since the expenditure of energy is reduced. Regimen, then, is here the essential feature. I have known old people, and even adults, who make a practice of putting themselves on half-rations, and remaining a day in bed once a fortnight.

The progress of surgery, on the one hand, and of pharmacology on the other, must not make us forget that it is always easier to prevent than to cure. A certain proportion of persons operated upon for appendicitis and gynæcological diseases derive much more benefit from the repose imposed by the intervention than from the operation itself when the latter was not very urgently indicated. A great many medicinal treatments are useless, and even injurious, if we lose sight of the fundamental element of the treatment—repose and rest. Medicine has everything to gain by getting rid of illusory and doubtful or ephemeral medications.

Lastly, when we are confronted with a disease of comparative specificity like tuberculosis, the safeguarding and utilisation of vital energy, along with reduction of digestive auto-intoxication, remains our sheet-anchor, hyper-alimentation only coming later.

Sir John Batty Tuke, recently giving evidence before the Royal Commission on the Care and Control of the Feeble-minded, at Westminster, advocated the division of England and Wales into five districts, in each of which there should be two resident Lunacy Commissioners instead of, as at present, the Commissioners all living in London. He compared the state of affairs in Scotland with that in England. In England three medical Commissioners supervised 121,979 patients, whereas in Scotland four medical Commissioners supervised 14,500. He drew attention to the simplicity of the Scottish system in lunacy administration and to the unnecessary amount of inspection of private asylums in England.

It is expected that the report of the Royal Commission on Vivisection is not likely to be presented to the King for at least a year. Meanwhile, it is announced that evidence will be published monthly.

THE TREATMENT OF SYPHILIS BY THE INTRA-MUSCULAR INJECTION METHOD: 100 CASES. (a)

By S. T. BEGGS, M.B., B.Ch.,

Gentlemen,—Having completed the treatment of 100 cases of syphilis by this method, I venture to place before you the following remarks:—

The treatment of syphilis by intra-muscular injections of mercury has been brought into prominence of recent years by Lieut.-Colonel Lambkin, R.A.M.C., and this method has been found to be well adapted for the treatment of syphilis in the Service, in which it is being used generally and is becoming more and more popular as a most suitable method of treatment.

The advantages claimed for the method are:—(1) The dose is definite; (2) fewer attendances are required; (3) it is a cleanly method; (4) professional secrecy is insured; (5) the action of the drug is more rapid; (6) less time is required in hospital; (7) the patient is able to attend to his daily duties during treatment.

The injection method is specially indicated (1) when rapid therapeutic effect is desired; (2) in syphilis of the central nervous system; (3) in hot climates where the gastro-intestinal system is more liable to be upset.

It is contra-indicated (1) in the case of patients who are about to travel and who cannot be seen at least once a week; (2) in very sensitive patients; (3) in patients suffering from marked cachexia.

The dangers and disadvantages brought forward against this method of treatment would appear to be exaggerated, and are avoidable by proper attention to detail of technique:—These are (1) embolus; (2) mercurial intoxication; (3) mercurial stasis, (4) sepsis, sloughing and inflammatory reaction. Thus Lieut.-Col. Lambkin reports the treatment of over 3,000 cases with 60,000 injections without a single complication. I have seen a case of inflammatory reaction, but this was in an alcoholic patient; also cases in which nodes were formed, but these caused no inconvenience to the patient. This latter condition indicates the non-absorption of the Hg. and is thus a guide to the diminution of the dose and the withholding of further injections until the mercury becomes absorbed.

The unabsorbed Hg. at the seat of the injection can be revealed by means of the X-rays. Therefore, before re-injecting a patient, it is always necessary to examine for nodosities.

The injections may be carried out by means of (1) the soluble salts; (2) the insoluble.

The advantages claimed for the soluble preparations are (1) their rapid effect; (2) the ease with which they can be given.

They are specially indicated in (1) tubercular cases; (2) in cases with extensive caries; (3) in cases in which the liver or kidneys are not acting well; (4) in young children; (5) in eye cases; (6) in the debilitated.

The disadvantages against their use are (1) the frequency of administration; (2) the effect is not so lasting as in the case of the insoluble preparations. This is due to the fact that much less Hg. is injected per dose than when the insoluble preparations are used.

(a) Read at meeting of the Ulster Branch, British Medical Association, Nov. 3rd, 1906.

The advantages claimed for the insoluble preparations are (1) fewer injections are required; (2) the effect is more lasting.

They are contra-indicated in (1) liver and kidney disease; (2) in the old; (3) in caries of the teeth; (4) in cachectic patients.

The disadvantages put forward need not arise if proper precautions are taken.

The dosage in intra-muscular injections varies with (1) the preparation used; (2) the weight of the patient; (3) the resistance of the patient; (4) the object aimed at.

Bing advocates beginning with a small dose first in order to test the patient's susceptibility.

The frequency of the injections will depend on whether the soluble or insoluble preparations are used. With the soluble salts daily injections may be required; with the insoluble preparations the injection is given every seventh or fourteenth day only.

The course consists of 20 to 30 injections of the soluble salts, and from 10 to 20 injections when the insoluble preparations are used.

The comparative values of the different methods of treatment are of interest: *e.g.*, one injection of mercurial cream (1½ gr. Hg.) is said to equal three injections of the soluble salt (containing ½ gr. Hg. in each injection) = seven inunctions of mercurial ointment (using 20 gr. Hg. daily) = 21 pills (containing 2 gr. Hyd. c. cret. t. in. die.).

The preparation most extensively used is Lambkin's:—

℞ Hydrargyri .. .. 1 ounce.
Adeps lanæ .. .. .. 4 ounces
Paraffini liquidi (carbol 2%) ad 10 ounces.

(Hg. and fat by weight, paraffin by volume). 10 min. = 1 gr. of Hg. pro. dos.

Special care is required in the dispensing of this preparation so that the Hg. is thoroughly mixed with the excipients. The Hg. and lanoline require to be triturated for two hours and then paraffin liq. carbol. is added and the whole well mixed. It is stocked in a wide-mouthed glass-stoppered bottle with rounded angles.

Many other preparations of the soluble and insoluble salts are used by different authorities. Of the insoluble salts calomel is the most effective, but it is painful.

PROCEDURE.

I.—Before injecting (1) the patient's weight must be noted; (2) the urine examined; (3) the liver examined and any recent intestinal trouble enquired into; (4) teeth and gums are examined, and any badly decayed teeth extracted.

II.—The site for injection must be carefully selected. The buttock is the most suitable, and here different points are advocated:—(1) The retro-trochanteric region (Smirnoff); (2) a point obtained by drawing a line horizontally two fingers' breadth above great trochanter with a line drawn vertically parallel to and two fingers' breadth outside inter-gluteal fold (Galliot).; (3) upper third of buttock (Fournier); (4) middle of line drawn from top of inter-gluteal fold to anterior superior iliac spine (Barthelemy).

The dangerous area, as defined by Möller lies between the posterior superior iliac spine and the great tuberosity of the ischium.

III.—The injections must be carried out with aseptic precautions; the needle used is rather longer than the ordinary hypodermic needle, and is made of platino-iridium. An all-glass syringe is used. The needle and syringe are sterilised and washed in boiling oil before each injection. The skin at the site of injection is rendered sterile by the ordinary surgical methods. The mercurial cream is kept at a temperature of 80° F. by the bottle being set in water maintained at that temperature, a thermometer being used as indicator. Care must be taken that the temperature of the water is not raised to boiling point, otherwise the Hg. will become separated and be deposited. Before the cream is taken up into the syringe, it is well stirred with an aseptic glass rod.

The injection is made in two stages:—(1) the needle is sharply thrust into the muscle vertically; (2) the syringe is then detached. This precaution will insure that a blood-vessel is not injured, and thus any danger of embolism avoided. Should any blood escape the needle is withdrawn and another site selected. After injection the skin is dried with an aseptic swab and the puncture touched with collodion. No pain is felt if the needle is thrust in sharply, and there are no after-effects beyond a feeling of slight stiffness in some cases where there has been much muscular exertion.

The next injection will not be given for a week or a fortnight. The interval between each injection and the dose will be determined by the nature of the case; no hard and fast rules should be laid down, each case being dealt with independently on its own merits.

Before re-injecting, unabsorbed mercury should be examined for; which will be indicated by the formation of a nodule at the site of injection.

During a course of intra-muscular mercurial treatment the ordinary precautions will be taken as to the condition of the teeth and gums, antiseptic and astringent mouth-washes being used, together with the toothbrush; the general health and dieting should be attended to, together with a judicious restriction in the use of tobacco and alcohol.

Bing gives the following as the signs that Hg. is agreeing with the patient:—(1) there is an increase in the amount of urea excreted; (2) the percentage of hæmoglobin is raised; (3) the body weight increases. The presence of albumen in the urine, or a decrease in the body weight will be indications for a temporary suspension of the injections. The length of a course of treatment will vary with the nature of the case, each case being managed independently. A general softening and a disappearance of the indurated lymphatic glands probably give the best guide. It is a safe rule to keep the patient under observation for at least two years.

THE OUT-PATIENTS' ROOM.

KING'S COLLEGE HOSPITAL.

Disorganisation of Joints.

By PEYTON BEALE, F.R.C.S.

A WOMAN, æt. about 35, came to the Out-patient Department complaining of intense pains in the right wrist, left elbow, and left knee. All these three joints were considerably enlarged and contained fluid; they were very tender to the touch and also when the least movement, passive or active, was attempted. In the case of the wrist and the elbow, very distinct bony crepitus was noticeable on slight movement in certain directions, and there was no doubt that in the case of the wrist there was disease affecting the intercarpal

joint and that it was practically disorganised. The elbow and the knee had not advanced to such a condition, but it was quite clear that they were affected in the same manner. The process was a slow one, for it had been going on for a year and a half and upon inquiry it was found that the patient had then suffered from a severe attack of acute rheumatism. The excessive pain in the joints had not been present continuously, but came on in exacerbations every few weeks.

A woman, æt. about 25, presented herself complaining of pain in the right knee; she could walk only with great difficulty on account of the pain, and also on account of the knee being kept slightly flexed. The skin around the joint was œdematous and on making firm pressure the patient experienced great pain. Normal movement was very limited, and was attended with crepitus or grating at times. There was a considerable amount of abnormal movement present, namely, lateral movement. Had it not been for the œdema, the severe pain and the semi-flexed position, the joint resembled a Charcot's joint with loose bone within it. On careful inquiry the symptoms were found to date from convalescence after typhoid fever about nine months previously.

Mr. Beale said that these two patients were suffering from a kind of more or less chronic pyæmia with acute exacerbations; the condition occurred as a sequela of acute specific fevers, such as scarlet fever, typhoid, rheumatic fever, and also after acute pneumonia. They were not at all like the pyæmic condition met with after gonorrhœa, for in the latter cases one could almost tell by the patient's aspect (sallow, earthy complexion), and the fact that there was a good deal of pain which moved from one joint to another. He said the cases above described were not common, but when they were met with they were seldom recognised; and were generally regarded as tuberculous. One of the characteristics of them, however, was that the condition was essentially a chronic one, associated with exacerbations, and during one of the latter it was not unusual for an abscess to form and to burst discharging thin, flaky pus with pieces of cartilage and even bone. He was in the habit of treating these joints by the application of a strong counter-irritant, together with pressure. In the first case of the kind he saw, some years ago, he advised amputation on general principles, for the wrist-joint was completely disorganised, the carpal bones were loose, and pus had been obtained with an exploring needle, but as the patient absolutely refused to lose her hand, he was obliged to treat it otherwise, and was considerably surprised to find that counter-irritation, in the form of red iodide of mercury ointment, carried to the extent of destroying the epidermis, and followed by firm pressure, not only markedly relieved the pain, but also resulted in the complete absorption of all the fluid and the consolidation of the carpal bones. He said that this condition did not seem to occur in the wrist (radio-carpal) joint, but in the inter-carpal joint; at any rate, so far he had not come across one affecting the wrist-joint proper. It was of course necessary to adopt constitutional treatment as well in the shape of tonics and plenty of fresh air.

OPERATING THEATRES.

ITALIAN HOSPITAL.

Paget's Disease of the Nipple.—Mr. Lenthal Cheatle operated on a woman, æt. 56, who had been admitted suffering from a red scaling surface over the position where the nipple had previously existed, the nipple having disappeared in the course of the disease. The red surface was dry; the base of the sore revealed a card-like infiltration; the patch was as large as a florin. The nipple of the other breast was normal; no glands could be felt in the axilla of the side of the disease. Scales had been scraped off, dried on a slide, mounted in a 40 per cent. potash solution, and examined immediately with a six-inch objective. There were seen imbedded in the scale, or floating in the serous discharge, bodies with a well-defined double outline and a central nucleus. On these physical signs, Paget's disease of the nipple was diagnosed. The trouble had a history of six months. Mr. Cheatle excised the whole of the breast, the fascia covering the pectoralis major, and the glands in the axilla. Great care was taken to prevent infection of the newly-formed wound during the removal of the disease by covering the raw-looking and septic surface with a small collodion and gauze dressing, and the incisions were so made as to render impossible any flow of blood over this dressing into the newly-formed wound. The edges were brought together by undercutting the flaps. Mr. Cheatle said that opinions seemed to be divided as to what Paget's disease of the nipple really was. Sir James Paget, who first described the lesion, so far as he (Mr. Cheatle) could see, made no definite statement beyond saying that within a couple of years or so the disease generally was associated with malignant disease of the breast. At the present time two schools of thought existed; one say that it is a condition which generally ends in malignant disease, and describe it under the vague term of malignant dermatitis, which means practically nothing definite; the other school regard the disease as malignant from the beginning; he himself agreed with the latter view. Some people, he said, in the treatment of this disease begin by the application of certain lotions with a view to its cure, and tell us that in some cases they are successful, but there can be no doubt that certain forms of Paget's disease are occasionally cured by the external application of certain remedies, but it is quite possible that in some of these cures the disease was not Paget's disease at all; in any case, it is impossible to tell how deep the disease has spread into the ducts unless microscopical sections are cut of the breast tissue underlying the nipple; it is therefore obviously wrong treatment to treat this disease by external applications when one is completely ignorant in any given case as to what depth the disease really has extended; the only safe course to pursue in every case is to excise the breast and glands, as had just been done. The disease is diagnosed from eczematous eruptions by the dry surface and card-like infiltration. In syphilitic lesions of the nipple the induration is much thicker and feels like a small lump.

Large sections of the whole breast were cut, and showed that the disease had spread deeply into the ducts—even as far as the alveoli in some parts. This proved that although the disease occupied a small area on the surface, it had spread too deeply to be influenced by any external remedy.

TRANSACTIONS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON.

Meeting held Friday, December 14th, 1906,

The President, Mr. Clutton, being in the chair.

Mr. G. A. Moynihan read a paper on

THE MIMICRY OF MALIGNANT DISEASE OF THE LARGE INTESTINE.

He gave detailed records of six cases upon which he had operated within the last few years. In all of these a diagnosis of malignant disease of the large intestine had been made at the time of operation or before, yet subsequent examination of the specimens

or the after-history of the cases showed that the diagnosis had been incorrect. In the first case, a woman, æt. 29, was operated upon for intestinal obstruction, due to a growth which blocked the rectum. Left inguinal colotomy was performed, and six weeks later the whole of the rectum and the sigmoid flexure below the colotomy opening were removed by the abdomino-perinæal route. An examination of the specimen, which was shown, revealed no evidence of malignant disease. The rectal walls were considerably thickened and stenosed. The mucous surface showed heaped-up irregular masses of soft growth, here and there ulcerated to a degree which resulted in festoons of mucous membrane being left, attached at each end, free in the middle. There were numerous deep pockets in the thick wall of the gut, due to ulceration. There was no evidence of tubercle or syphilis.

In Case 2, a woman, æt. 58, there was a large tumour of the sigmoid flexure, with perforation, and a localised abscess. The patient was operated upon for acute obstruction in 1904. The tumour has disappeared entirely, and the patient is quite well. The case was considered to be one of subacute perforation of a false diverticulum of the sigmoid.

Case 3, in a woman, æt. 50, was an example of inflammatory tumour, due to pericolitis transversa affecting the left end of the transverse colon. Colectomy was performed for a tumour as large as a cocoanut. Subsequent examination showed only an immense thickening of the outer coats of the intestine; the mucous surface was intact.

Case 4, in a woman æt. 41, was similar to Case 1.

Case 5 occurred in a man æt. 52 who was operated upon for symptoms of duodenal ulcer, and who had suffered for some months from intermittent attacks of acute intestinal obstruction. A large duodenal ulcer was found. When the large intestine, a growth in which had been suspected, was examined, a tumour as large as the fist was felt in the sigmoid flexure. This was removed and axial anastomosis performed. The tumour on section showed a large number of false diverticula, one of which had perforated. The walls of the gut were 1¼in. thick. No evidence of malignancy could be discovered.

Case 6, in a woman æt. 62, was one of inflammatory tumour of the splenic flexure, which disappeared entirely after a shortcircuiting operation.

In drawing attention to these cases, Mr. Moynihan remarked that the mimicry of malignant disease in the cæcum and ascending colon by a hyperplastic tuberculous process was well known. He had performed colectomy on two such cases in the belief that he was dealing with cancer. It was, however, not so generally known that inflammatory tumours presenting all the clinical appearances of cancer existed in all parts of the large intestine. Many of these were possibly due to the presence of false diverticula, the origin and complications of which were discussed.

The PRESIDENT alluded to the importance of Mr. Moynihan's paper. He drew an analogy between the cases just described and those of gastric tumours, which were thought to be cases of cancer, but which disappeared after gastroenterostomy. As to the rectal cases that were usually assumed to be due to a gummatous interstitial myositis, he was extremely sceptical about the syphilitic nature of many of them.

Dr. BROOK (Lincoln) related a case of a patient, æt. 65, who had been operated on for acute intestinal obstruction. A fixed tumour of the cæcum had been found, and shortcircuiting performed. Eighteen months after the man was perfectly well, and there were no signs of any tumour.

Mr. W. G. SPENCER had operated on a similar case, and seven years afterwards the intestine proved at autopsy to be quite normal. He suggested that many of the cases of so-called malignant disease that recovered after exploratory operation alone must be of this nature.

Mr. MOYNIHAN, in reply, said that though at first he had thought that one of the cases was syphilitic he had failed to find any evidence at all confirmatory of this. He considered that differences could be established between the appearances of the non-syphilitic and true syphilitic cases. In the literature he had found notes of forty cases of false diverticula of the large intestine. He had seen, however, in museums specimens of a number equal to this, but wrongly described as malignant disease.

Mr. JAMES BERRY read an account of

A CASE OF TRAUMATIC HERNIA THROUGH THE DIAPHRAGM.

A railway man, æt. 19, was admitted to the Royal Free Hospital on November 11th, 1898, having been squeezed between buffers shortly before admission.

He was greatly collapsed, and there were physical signs of rupture of the left lung, with much effusion of blood and air into the left pleura. It was believed from the nature of the injury that the diaphragm also had been injured. During the next three days he remained in the same extremely bad condition. The heart became more and more displaced to the right, and the pneumo-hæmothorax increased. He vomited occasionally.

The circumference of the abdomen measured 28½ on admission, but gradually diminished to 24½ inches. On the evening of November 15th the vomiting became much more frequent and violent; the vomit evidently contained much altered blood. As the symptoms pointed to strangulation, it was decided that, desperate as was the man's condition, an attempt ought to be made to reduce the strangulation. The abdomen was opened. A large rent in the left posterior part of the diaphragm was discovered. Through this most of the stomach and transverse colon, all the great omentum, one half of the spleen (which had been cut in two), and the upper end of the left kidney had passed into the thorax.

The herniated viscera were grasped moderately firmly by the edges of the opening in the diaphragm, and were drawn back into the abdomen with some little difficulty. The rent in the abdomen was closed, partly with sutures and partly by fixing the left lobe of the liver so as to block up the posterior part of the opening, which could not be sutured. The operation lasted half an hour, and the patient died almost immediately afterwards.

The difficulties of diagnosis in this case were considerable, owing to the similarity of the physical signs of pneumo-thorax and hernia of the stomach, and to the fact that both these conditions co-existed.

The diminution in the circumference of the abdomen and the subsequent vomiting of coffee-ground material were the main points upon which the diagnosis of hernia of the stomach was made.

Mr. J. PAUL ROUGHTON read an account of

A CASE OF RUPTURE OF THE DIAPHRAGM.

The patient, a shunter, æt 49, was admitted into hospital, October 27th, having been squeezed between buffers. Examination revealed no lesion of importance, but patient complained of pain in the back and precordia.

On October 28th the severe pain continued; it was increased on swallowing. The right hypochondrium was slightly retracted. The movement of the chest on the left side was impaired; the cardiac dulness was absent, and left side of the chest hyperresonant.

The diagnosis was confirmed upon opening abdomen. The patient's grave condition only allowed of the stomach, which had risen high into the chest, being pulled down, and the wound stitched. There was passage of blood from chest into abdomen upon traction of stomach. The patient died October 29th. 1 a.m.

Post-mortem.—The left lung was completely collapsed. The chest contained about three-quarters of the stomach; the spleen also was in chest. The diaphragm torn away from its attachment between the ensiform cartilage and ninth rib, thus forming simply a shelf between the chest and abdomen. There was a tear in the spleen, probably the source of the blood, which flowed from the chest into the abdomen. The points to be specially noted are (1) the unequivocal nature of the signs of rupture; (2) the delay of serious symptoms which made the case an apparently favourable one for operation.

The President commented on the great interest of the cases.

Mr. W. G. Spencer congratulated the authors as aiding in the introduction of operative measures in these cases. He alluded to the analogy from a surgical point of view between them and the congenital cases.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Surgery.

President: H. R. Swanzy, President R.C.S.I. Sectional Secretary: Edward H. Taylor, M.D., F.R.C.S.I.

Meeting held Friday, November 30th, 1906.
The President in the Chair.

SPHINCTERIC CONTROL OF THE BLADDER IN RELATION TO PROSTATECTOMY.

Mr. Arthur Ball read a paper on the above subject. Having pointed out that it had generally been accepted that in man the important muscle was the compressor urethræ, he described a case of perineal prostatectomy in which there had been almost perfect control through the perineal fistula after the drainage tube had been removed five days after the operation. In this case control must have taken place by means of the internal sphincter vesicæ. As the result of this observation, Mr. Ball had carried out experiments on dogs, having ascertained the anatomical similarity was greater in the dog than other animals, including the commoner forms of monkeys. These experiments, which were described in detail, proved that the important sphincter muscle in the dog was the internal sphincter vesicæ. Incidentally, he pointed out that the prostate might enlarge to an enormous size in the dog without producing any symptoms. In conclusion, he stated that in order to prove absolutely that in man the internal sphincter is the important muscle, it will be necessary to obtain observations on all cases of surgical interference with this region, particularly in young patients that have not reached the complication of an enlarged prostate, and that it seemed quite incorrect to argue from operations on patients with enlarged prostates that the chief sphincter of the bladder normally lies in the membranous urethra.

Mr. T. E. Gordon considered the communication one of the most important which had been laid before the Academy for some time. The experiments appeared to be conclusive as far as they went, and as far as it was possible to draw inferences with regard to human physiology from the anatomy and physiology of the dog.

Mr. Jameson Johnston said it had been difficult for him to account for the complete control after suprapubic prostatectomy. He could not conceive that the internal sphincter could exist after the amount of manipulation which it had to undergo, and he thought the amount of damage done to the bladder wall would prevent the internal sphincter from acting again.

Mr. Gunn said that in cases where the prostate had been removed by the suprapubic method, and where he thought the internal sphincter was either destroyed or taken away, good control had been got. He believed that the compressor urthræ muscle was the most important to leave behind when interfering with the bladder.

LIMITS OF ABDOMINAL OPERATIONS.

Mr. T. E. Gordon read a paper on the above subject, and, in the course of his remarks, discussed the indications for fixation of a movable kidney. He drew a distinction between those cases in which the symptoms were clearly referable to the kidney and those which were only "associated." Amongst the latter he specially referred to vomiting and other evidences of gastric disturbance. Whilst operation seemed justified in the first class, in the second it was likely to be disappointing in its result. He held that the vomiting, though, no doubt, occasionally a nervous reflex phenomenon, was usually caused by a gastroptosis, and could not therefore be benefited by a nephopexy. He specially insisted on the folly of operating to cure a general neurotic state. Mr. Gordon considered that the proper limits of operation had been exceeded in cases of movable kidney, but he did not think that this had been the case in the treatment of appendicitis. He thought that one attack of appendicitis was sufficient to justify operation, but this attack must have been unequivocal. The difficulty here lay in diagnosis, and he gave instances of such difficulty which he had met with in practice, and he said that the difficulties arose from the remarkable variability of the disease. Thus one might see appendicitis without fever, and sometimes without distinct tenderness in the right iliac fossa. Again, the position of the tumour varied, and he had met with a case of undescended cæcum where the appendix was coiled up close to the gall bladder and pylorus. He also referred to the association of appendix pain with pneumonia. In conclusion, the limits of operation in the surgery of the stomach were briefly alluded to, particularly with reference to gastro-enterostomy as a treatment for gastroptosis. Here again a decided neurotic element was a bar to operation.

Mr. W. Taylor said it was not always easy to be certain that symptoms were distinctly referable to movable kidney. In his experience a larger proportion of cases of stomach trouble than Mr. Gordon appeared to concede were due to movable kidney. The speaker instanced several cases bearing on the point, as also on the difficulty of diagnosis in appendicitis.

Mr. Jameson Johnston agreed that only cases in which the symptoms were directly traceable to misplaced kidney should be subjected to operation. He had never seen two cases of appendicitis exactly alike, and he would be glad to have information as to the exact indications for operation.

Mr. Gunn thought that in almost every case where they got a tumour in the appendix region pus was present. He referred to kinking of the ureter as a test.

Mr. Blayney said that Mr. Gordon's statement that it was inadvisable to operate in acute appendicitis while inflammation was present should not be allowed to pass without some qualification. It was, of course, advisable not to operate if it could be ascertained certainly that the patient would recover. But there was no definite way of doing so, and he believed that if patients were all operated on in the first 24 hours in acute appendicitis, there would be less harm done than by adopting the waiting policy.

Messrs. Ball, Stokes, and Kennedy also spoke.

HARVEIAN SOCIETY.

Meeting held Thursday, December 6th, 1906.

Dr. W. F. Cock, President, in the Chair.

Dr. Robert Boxall opened a discussion on

THE MODERN METHODS OF DEALING WITH ORDINARY CASES OF LABOUR.

He referred to the mortality in lying-in hospitals 30 years ago, which then amounted to 14 per cent. This had greatly decreased of late years, but the mortality in cases not treated in hospital was still very high. He thought that the main cause of the high mortality was septic absorption from laceration of the parts or use of instruments, and the imperfect methods of employing antiseptics by those not specially trained in their use. It was not merely the use of antiseptics, but the proper methods of employing them, which had led to such a great improvement in the statistics in lying-in hospitals. Training in the use of antiseptics was as important for students as it was for nurses and midwives, and neglect of proper training of the former might be accountable for the high mortality of private cases as compared with that of lying-in hospitals.

Dr. Horrocks referred to the time, 100 years ago, when pyrexia, after delivery, was the rule, and lying-in hospitals were regarded as a hot-bed of infection. The proper use of antiseptics subsequently effected a great change and improvement in statistics. Syringing was

introduced, and freely used, but discontinued when it was seen that the hand of the accoucheur most commonly introduced the septic material. Attention was then paid to rendering the hand aseptic. He considered that nature effected delivery by herself better than any artificial aids employed to assist her. He did not approve of the administration of chloroform or the use of forceps unless absolutely unavoidable. Even if forceps were used with strict antiseptic precautions, laceration and tears often ensued, and gave rise to troubles later on. At Guy's Hospital forceps were only applied in 4 or 5 per cent. of cases, and the mortality was very low. He did not consider that gonorrhœa was a cause of puerperal fever, though it might give rise to ophthalmic neonatorum. He deprecated the routine dropping of irritating lotions into the eyes of new-born children, which might, in the absence of gonorrhœa, give rise to severe ophthalmia.

Dr. HUBERT PHILLIPS said that the mortality in his cases of midwifery was only 1 per cent. He usually examined more than once, always using strict antiseptic precautions. He left delivery to nature as far as possible. He only douched after instrumental delivery, and then only once, as a rule.

Dr. ADAMS did not approve of the administration of chloroform, as he considered it had a marked effect in diminishing the pains, and often necessitated the use of instruments.

Dr. BLUETT considered that laceration of the perinæum might, with proper care, be prevented in the majority of cases, even in primiparæ and when forceps were employed.

Dr. PAYNE raised the question as to whether the routine use of ergot was advisable.

Dr. HANDFIELD-JONES said that a distinction must be drawn between hospital and private cases. For instance, chloroform was seldom necessary in the former, but was often essential and beneficial in the latter. If used in moderation, it did not interfere with labour in the first and second stages, and in the third stage it might prevent rupture of the perinæum. For hospital cases ergot was seldom necessary, but in private cases its use was frequently called for. He did not agree with Dr. Boxall that the mortality in cases treated out of hospital was due to deficient training of students in the use of antiseptics. The statistics of maternity cases treated at their own homes by students at the large hospitals was very low. The high mortality was due rather to the insanitary surroundings of poorer patients, and, above all, to examination of the patients by unskilled, "so-called" midwives, who infected cases before they were seen at all by a doctor.

Dr. LEWERS maintained that it was advisable, as far as possible, to make out the position of the child by external examination only, and dispense with vaginal examination in the majority of cases, as absolute disinfection of the hands was scarcely possible, and vaginal examination was therefore a source of danger. If this was necessary, sterilised rubber gloves should be worn. Some cases of sepsis occurred in spite of all precautions, probably from the introduction of pathogenic organisms from the vulva, which might be carried in by the finger or by douching.

The PRESIDENT held that a large proportion of cases of septic trouble were due to infection by an ignorant midwife. He would say, "Mark well your hands; therein the danger lies."

GLASGOW EASTERN MEDICAL SOCIETY.

MEETING HELD DECEMBER 5TH, 1906.

The President, Mr. THOMAS BARRAS, in the Chair.

Dr. JOHN PATRICK showed a case of

MALOCCLUSION OF THE JAWS,

which had been rectified by Mr. J. J. Manson, L.D.S., Glasgow. The patient was shown last year to the society, and at that time he could not bring his incisor teeth together, although the molars could be brought into apposition. He was partially starved owing to the difficulty created by imperfect mastication. Mr. Manson removed the posterior molars and fitted, in the mouth, a plate with artificial teeth. The result was very satisfactory, as the lad had gained in weight, and his facial expression was rendered comely. The case appeared to be congenital, as his father and two brothers had been similarly affected

Dr. SAMUEL CAPIE showed a case of "winged scapula," and a case of localised "œdema of the face." The former he considered was due to paralysis of the serratus magnus, from neuritis.

Dr. DAVID COUPER showed a case of extensive

CARBUNCLE

in the neck, in which he had operated with success. He said it was the largest one he had seen. It was at least 4 in. by 4 in. The patient was put under chloroform, the carbuncle incised, freely scraped and cauterised with pure carbolic acid. Healing was rapid, and a comparatively small scar left.

Dr. WILLIAM CHRISTIE related several cases, where he had incised carbuncles by free incisions with good results. In one case, where the patient had saccharine urine, he succumbed.

Dr. MACLACHLAN stated he had been in the habit of ordering wet boracic dressings, covered with oil silk to carbuncles, the dressings being renewed frequently. At the same time he put the patient on 2 grains of quinine every few hours. Under this treatment most cases of carbuncles gradually quieted down and dwindled, leaving a small indurated lump, which finally disappeared. If a carbuncle had burst it was desirable to remove the sloughing material with as little delay as possible. By using dressing forceps, sloughs could be twisted out, leaving a cavity which rapidly healed with iodoform dressings.

LIVERPOOL MEDICAL INSTITUTE.

MEETING HELD THURSDAY, DECEMBER 6TH, 1906.

The President, FRANK T. PAUL, F.R.C.S., in the Chair.

EXHIBITION OF CLINICAL CASES, ETC.

THE PRESIDENT showed a patient, 63 years of age, from whom he had partially removed an epitheliomatous cyst which had been growing for two years under the left sterno-mastoid muscle. The cyst contained a clear brown fluid and flocculi, and its walls resembled those of a dermoid cyst. There was too much surrounding infiltration to permit of the complete removal of the growth. The microscopical examination of the portion removed showed that it was a deep epithelioma.

Mr. DAMER HARRISSON, Mr. W. H. BROAD, and Mr. ALLAN PINDER also showed surgical cases, while the President and some other members exhibited their portable operating tables.

Among the medical cases were a rare case of myositis ossificans, shown by Dr. J. Hill Abram; a case of mitral stenosis, with no cardiac murmur, but with marked backward pressure in the veins, shown by Dr. T. R. Bradshaw; fibroid lungs, by Dr. R. J. M. Buchanan; aneurism of the aorta, innominate artery and right carotid, and a case of exophthalmic goitre, which was improving under the internal administration of rodagen, by Dr. A. G. Gullan.

An instructive series of skin cases were shown by Drs. F. H. Barendt, H. Leslie Roberts, and G. Stopford Taylor. Among Dr. Taylor's cases was one of Recklinghausen's disease, with elephantiasis of the left leg and fibroma of the palm. The patient was a woman æt. 44 years. The leg began to swell 23 years ago, and now measured 35 inches around the calf. The fibromata of the palm and trunk had begun 20 years ago. Dr. Taylor also showed a girl, 5 years of age, with urticaria pigmentosa, which began when the child was 9 months old.

A number of interesting eye cases were exhibited by Mr. T. H. Bickerton, Dr. K. Grossmann, and Mr. Charles G. Lee.

BRACHIAL PALSIES.

Dr. W. B. Warrington read a paper written jointly by himself and Mr. Robert Jones entitled "Observations on the Palsies of the Brachial Plexus, and Some Remarks on Recent Work on Treatment of the Lesions of Peripheral Nerves."

The paper was discussed by Mr. Damer Harrisson, Mr. G. G. Hamilton, Mr. R. W. Murray, and Prof. A. M. Paterson.

ULSTER MEDICAL SOCIETY.

Meeting held Thursday, December 13th.

The President, Dr. D. P. Gaussen, in the chair.

Dr. John Campbell read a paper on

THE USE OF RUBBER GLOVES IN MIDWIFERY PRACTICE.

He advocated their routine use, both on account of the additional safeguard to the patient and also on account of the ease they gave to the medical man's mind, for, if infection did occur, he felt that he had done all in his power to avoid it, and had taken every possible precaution; whereas, if gloves were not worn, he might feel that, if only they had been, infection might not have occurred. He gave some account of the very general use of gloves in some districts, and then described the way in which he used them, taking them to the house where they were to be used and boiling them there in an ordinary saucepan. The only objection to their use was that the patient or her friends might think one was afraid of soiling his hands, or feared infection for himself, but the public was intelligent in such matters, and soon appreciated the advantages obtained by their use.

The paper was discussed by the President and Dr. Kevin.

Dr. Campbell also showed (a) a hydatid mole; (b) two hundred and sixty-two gall-stones recently removed from a gall-bladder; (c) eight hundred and two gall-stones removed from a gall-bladder and cystic duct.

Drs. Darling and James Wilson read notes of "A Case of Cerebro-Spinal Meningitis, from the Lumbar Puncture Fluids of which a Pleomorphic Diplococcus was Isolated." Details of this case, which is of peculiar interest, will be published later. It was discussed by Professor Symmers, who congratulated the authors on a most successful piece of research work.

Drs. B. H. Steede (Rostrevor) and G. A. Hicks (Belfast) were elected Fellows of the Society, and Drs. John O'Doherty, P. T. Crymble, and W. Hill, all of Belfast, were elected members.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, Dec 16th, 1906.

CIRRHOSIS OF THE LIVER.

As soon as the disease is recognised, the patient should be enjoined the reclining position to facilitate the circulation of the liver. Absolute milk diet is one of the most important conditions of a cure. It should be continued until the complete disappearance of all the morbid symptoms, and for several months afterwards, before he is allowed to return to his ordinary régime.

From this régime, however, should be excluded all alcoholic liquors, condiments, acid fruits, pork, meat, fish, and shell-fish, fats, and "high" meat.

As to the medical treatment, Professor Robin gives a primary place to iodide of potassium, which he considers preferable to iodide of sodium, and might be prescribed with strychnine.

Iodide of potassium	dr. j.
Sulphate of strychnine	gr. ½.
Water	ozs. x.

A tablespoonful before the two principal repasts.

Strychnine acts on the nervous system, while the potassium stimulates the vessels.

To increase the biliary secretion, salicylate of soda constitutes the best cholagogue. However, it is not always tolerated, and might be replaced by benzoate of soda or phosphate of soda, to which is added small doses of jaborandi.

Benzoate of soda	gr. v.
Phosphate of soda...	gr. x.
Powdered jaborandi leaves	jj.

For one wafer. Two a day one hour before meals. To further increase the secretion, the wafer might be taken in an infusion of boldo (half a drachm for 6 ozs. of water).

Some authors have tried massage, but the experiments cannot as yet be said to be conclusive.

Each evening the patient should take a more or less drastic pill.

The above treatment may be applied to all cases of cirrhosis. However, complications may require something more.

In certain patients oliguria is frequent, and the best treatment in such cases is theobromine, associated with phosphate of soda.

Theobromine ... ... } Phosphate of soda ... ... }	aa gr. x.

For one wafer; three daily at one hour's interval between each.

In case of failure the following pills might be prescribed:—

Powdered squills ... ... } ,, digitalis ... .. } ,, scammonium ... ... }	aa gr. 1.

For 1 pill; 2 to 4 in the 24 hours, or

Acetate of potash ... ... } Nitrate of potash ... ... }	drs. ss.
Oxymel scillæ	oz. j.
Infusion of broom flowers	ozs. v.

A tablespoonful every hour.

Calomel is a good agent at times, and might be given in two-grain doses every four hours, but not more than eight grains should be given in the 24 hours.

If ascites is abundant and oliguria persists, the liquid should be tapped, and when the abdomen is evacuated the medical agents act with renewed activity.

The most unfortunate complication in cirrhosis of the liver is hæmorrhage; it constitutes frequently the initial symptom, and is sometimes extremely abundant. As soon as it presents a certain gravity the treatment of acute anæmia should be applied, absolute rest, repeated injections of serum, etc. In benign cases chloride of calcium should be prescribed.

Chloride of calcium	dr. j.
Syrup of opium	oz. j.
Water	ozs. v.

A tablespoonful every hour.

NOISES IN THE EAR.

Noises in the ear, independent of any local lesion, are best treated with bromide of sodium, at the dose of 30 or 40 grains, in a little water an hour before bedtime, or

Bromide of potassium	dr. j.
Bromide of sodium	dr. j.
Bromide of ammonia	dr. ss.

dissolved in a bottle of effervescing mineral water, of which one or two wineglasses may be taken before bedtime, and continued three weeks.

During this treatment, says Dr. Huchard, the patient should abstain from fatty or acid foods.

In numerous cases the following gives excellent results:—

Bromide of sodium	grs. 30.
Antipyrin	grs. 4.

To be taken before bed-time.

Where vertigo accompanies buzzing, quinine should be prescribed in two-grain doses, three times a day.

If the noises persist, a blister might be ordered behind the ear.

DR. DOYEN'S TREATMENT OF CANCER.

Dr. Doyen presented to his colleagues about fifteen patients treated by him for divers forms of cancer.

Certain patients considered incurable four years ago are to-day in a very satisfactory condition. The general state seems excellent, and the tumours have either receded or not increased. One of the patients had been operated on some years before for cancer of the stomach; the malady subsequently invaded the walls of the abdomen, creating a gastric fistula. Under the influence of the Doyen treatment, the fistula closed spontaneously.

The meeting was much impressed with the results of the anti-cancerous vaccination.

GERMANY.

Berlin, Dec. 16th, 1906.

AT the Medizinische Gesellschaft a discussion took place on Hr. Lewins', note on

ACOCANTHERA SCHIMPERI

reported in your issue of December 5th.

Dr. Stadelmann observed that at the suggestion of Hr. Lewin he had made some trials of the drug. First of all he used a decoction of the wood, 0.5 gm. to 150.0, but the dose was too small. Other modes of preparation, such as maceration, had proved useless. Going very cautiously by trials on himself and others he had arrived at a proper dose according to the following formula: Inf. acocanth. 1.0 to 160 grm.; Syr. Simp. 30.0; Aq. Menth. Pip. 10.0.

In this form it proved a slightly bitter medicine, but one taken readily and always well borne by the stomach.

Of the mixture he gave one tablespoonful every two hours and continued it for four to five bottles of it. If no effect was produced by this, none need be expected.

A total of 29 cases had been treated with it, amongst them the most varied forms of heart disease and nephritis.

Pulse and blood pressure were sometimes not affected at all, at other times very much, as happened also with digitalis.

The secretion of urine was sometimes increased, and the general condition frequently much improved.

Taken as a whole, acocanthera was an important substitute for digitalis and digitalin, to which it was sometimes not equal in activity, but which it sometimes exceeded very considerably. It had the advantage over digitalis that it did not lose its power by long keeping. Further investigation in the clinic should, however, be made with it, before it was introduced into general practice.

He had also given ouabain injections 0.004 to 10.0 grm. They caused no trouble and were given three or four times a day. The results appeared to be very fine, but the observations were not sufficiently numerous. If the efficacy was confirmed it would be a great gain, as the action was rapid, and digitalin injections had to be given up on account of their great painfulness.

Dr. Brieger had obtained from arrow poison a crystalline substance three times the strength of the poison itself. He doubted the chemical purity of Lewin's amorphous ouabain, and none but pure chemical substances should be introduced into medicine. It was a guarantee of purity when the substance was crystalline, and it must be our aim to procure such a substance There were several bodies with the name ouabain that were not identical, and there were also various species of acocanthera.

Hr. Franz Müller asked if investigation had been made as to whether, unlike strophanthine, it had but little influence on the walls of vessels, and if it was cumulative in action.

Hr. Lewin in reply maintained his original position.

Hr. P. Rosenstein reported the case of a young girl who had had

BOTH KIDNEYS OPERATED ON.

In a young girl whose right kidney had been extirpated for calculi he found stones also in the left. As she expressed a desire for operative relief, he decided to operate, but with reluctance. He opened out the left kidney and made an incision, the kidney having been first rendered bloodless, and removed 35 cystine calculi. It was remarkable that the kidney was scarcely enlarged; the parenchyma was very much thinned. He closed the kidney by suture, drained the pelvis, and closed the external opening with the exception of the part occupied by the drain. During the first two days not a drop of urine was passed, and the heart was very weak. Stimulants or excitants were freely given. The urinary secretion started on the third day. Recovery took place, and the patient might be looked upon as safe. Since the operation, three months ago, she had got quite well, and she had now a normal excretion of urine, both in quantity and quality.

Hr. H. Isaac showed a girl with a primary sore on the mamilla, and also one at the same time on the lower lip. The sores as shown by subsequent roseola were syphilitic. The speaker was of the opinion that extragenital syphilis had increased during recent years, and suggested an enquiry into the matter.

At the Gesellschaft fur Psychiatrie und Nerven Krankheiten

Hr. Plant, of Munich, spoke on

THE OCCURRENCE OF SYPHILITIC ANTIBODIES IN THE CEREBRO-SPINAL FLUID OF PARALYTICS.

His investigations had been carried out in association with Prof. Wassermann. It was ascertained that in the large majority of cases syphilitic antibodies were found in the cerebro-spinal fluid of paralytics, and in a smaller proportion in the serum also. In 38 out of 48 cases examined these antibodies were found. In six cases the investigation was negative, in four doubtful. In ten cases the serum could also be examined, and in all in which the antibodies were present in the cerebro-spinal fluid, they were found in the serum as well. Twenty-three non-paralytics had no antibodies. Among the cases in which the absence was not positive, the patient's history showed syphilis in some instances. There appears to be no binding connection beween the clinical facts and the biological condition. Old cases and recent cases behaved much in the same way It was a question whether the production of antibodies did not run in curves, so that at one time a positive condition was met with, and at another a negative. In 16 cases lymphocytes were looked for and found in all, but some of the cases did not show the antibodies. In four cases of cerebral syphilis the antibodies were not found with certainty. An old syphilitic without central symptoms gave a negative result. The result showed that the majority of paralytics were syphilitics, but nothing further could be said at present as to the connection between the two. In no case were there fewer antibodies in the cerebrospinal fluid than in the serum. If it could be determined that the antibodies had their origin in the central nervous system, then some syphilitic process must go on there.

Hr. Zieben spoke of the frequent remissions that took place in dementia paralytica as compared with brain syphilis, and suggested that comparative investigation should be made before and after the remissions. The negative result would show that only few antibodies were present, and that the alexin of the cerebrospinal fluid was completely withdrawn.

Hr. Plant, in reply to various speakers, said that mercurial treatment did no good, that Hr. Zieben's suggestion was a good one, and that it was yet too early to answer questions.

AUSTRIA.

Vienna, Dec. 16th, 1906.

OSTITIS DEFORMANS—PAGET'S.

KUTSCHA presented a patient to the Gesellschaft from Eiselsberg's clinic, with a form of osseous deformity recognised as Paget's. The subject was a female, æt. 56, who appears from the history to have been complaining for the last five years of pains of an indefinite character. A few months after the advent

of pain the bones of the legs began to swell, and still later the left arm. A few months after this she was attacked with severe lancinating pains in the back of the head and forehead, associated with vertigo and dulness of hearing, especially in the left ear. The head on measurement was greatly enlarged. During this time the ankles and bones of the legs were bending outwards and increasing in thickness, but the pain had ceased. On the other hand, the pain was intense in the upper arms and head, the latter often feeling as if it would split.

With the Röntgen rays cysts in the bony structure with a fine reticular web between were observed.

Fungus on Knee and Elbow Joints.

Salzer presented a girl, æt. 6, with a fungus on both elbows and knees, which he had treated with Spengler's tuberculin with good results. The child was greatly reduced, with right knee contracted at right angles, and much swollen. Both elbows were in a similar condition; from these three parts discharges of an offensive character exuded. The treatment has not long been commenced, yet the left leg is already in a state of extension. This limb was first bound with ointment till dry with the injections.

At first the dose was one-tenth of a milligram, and was very slowly increased, giving the minimum of reaction; only once was the temperature raised to 39° Centigrade. At present Salzer is injecting two milligrams, and has released the left elbow from its ankylosed condition; the right elbow has still a good deal of fungus about it, though far less than when the treatment was commenced, but the fistula still exists. The knee joint in extension is quite healed, and the swelling gone. Considering the severity of the case, he thought this was a wondrous improvement in so short a time. He anticipates a perfect recovery by a continuance of the treatment.

Röntgen Rays.

Benedikt showed a few Röntgen plates to prove that the rays were of more service to the clinician for diagnostic purposes than to distinguish bones, air passages, and soft swellings. Radiologists who could only do this were using defective apparatus, as exudations and blood effusions could easily be distinguished between the cranium and cerebral substance; even soft swellings can be easily recognised on the plates. He believed that with daily progress on the improvement of the instrument it would be easy to diagnose any trifling disturbance that was accessible by the rays.

Bilious Typhoid.

Kretz shewed a few blood preparations taken from a patient suffering from bilious typhoid in one of the Smyrna hospitals. On the sixth day of the disease a large number of recurrent spirochætæ were found, which proves that the classic bilious typhoid of Smyrna requires further bacteriological examination to determine whether the disease is connected with typhoid or identical with the icteric fever of the Orient, or should be isolated entirely from both as bilious typhoid.

Pathology of Atrophy.

Bum gave a report of his experiments with animals to determine the question whether disease and injury of a joint or the inactivity produced muscular atrophy. Paget attributed this to reflex tropho-neurosis, Salzer to inactivity. His experiments were overwhelmingly in favour of inactivity, although reflex influences played a part in the articular atrophy. It cannot be denied that neurotrophic changes in the skin, hair, nails, cellular tissue and bony structure are present.

Isenschitz said that Bum's results were not in accord with clinical experience. He related a case of fungus in the navicular bone where the muscular atrophy was entirely due to the morbid process, and not to inactivity.

We regret to learn that Mr. Walter John Sykes, M.D., of Westfields, East Grinstead, editor of *The Analyst*, and late medical officer and public analyst of Portsmouth, was found dead in bed on the 16th instant.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

PROPOSED COMPULSORY NOTIFICATION OF PHTHISIS IN EDINBURGH.

The Convener of the Public Health Committee makes the following statement in reference to the adoption of this measure:—Apart from notification to the local authority of every case in the district new powers are given to deal with the disease by the Infectious Diseases (Notification) Act. Every one competent to speak authoritatively recognises that compulsory notification is absolutely necessary to acquire complete information as to the extent of the evil. As to the procedure which will follow notification, the cases may, in general, be divided into two classes. First, when the doctor in attendance can guarantee that the patient can be properly looked after at home in the matter of disinfection of the premises, prevention of infection by the sputum, etc., nothing further will be done, except that the doctor will notify from time to time as to the progress of the case, and will instantly notify any removal, so that the house may be thoroughly disinfected before another tenant enters. Where the patient's circumstances are not such as to ensure that such measures will be effectively carried out, visits will be made by the inspector under the Medical Officer of Health. The house will be thoroughly disinfected, and the patient instructed as to what precautions he must take to prevent the spread of the disease. So long as the directions given are followed out the patient will be allowed to live in his own house. Compulsory notification will give information of every case in the city, and those which on account of their advanced stage are dangerous to the community will be removed to hospital.

A few more beds than the 50 set apart for phthisis will be required, but not more than 100 in all. The deaths from consumption in Edinburgh number about 400 annually. Taking the average duration of each case at three months, the 100 beds would provide accommodation for 400 cases in a year. It is impossible to state in advance accurately what the expense will be, but for the first year it is thought that two additional men in the Health department—an inspector and a disinfector—will be enough. This will absorb £120. With regard to notification fees there is a precedent from Sheffield. In 1904, when compulsory notification was adopted, there were 826 cases and 536 deaths; the following year the deaths numbered 490 and the cases 741. In Edinburgh the estimate is that the cases will not exceed 800, which with notification fees at 2s. 6d. and 1s., should not bring the total cost of the scheme to more than £300. There is no provision in the scheme for sanatorial care of early cases, for the cure of disease does not come into the general schemes of public health administration. The consumptive patient is not himself infectious; the danger resides in the sputum, and if that is looked after he is practically free from danger so far as the community is concerned.

On the motion of Councillor Macpherson it was agreed that the public health committee recommend the town council to obtain powers from the Local Government Board to place consumption under the infectious diseases notification act.

Administrative Control of Phthisis.—Some further explanation of the Local Government Board's circular have been furnished in a correspondence between the Secretary of the Board and a medical officer of health, which has been published in the *Scotsman*. In reply to a query by the latter as to the procedure to be adopted, and the advantages of compulsory notification, in the case of a local authority acting under the instruction of the Board, and treating phthisis as coming under the Public Health Act, Mr. Falconer Stewart writes: "I am to explain that phthisis as an infectious disease falls to be dealt with by the local

authority in the manner most appropriate to the character and the peculiar nature of its infectivity. It cannot be said that there is a method of procedure common to all infectious diseases. Each disease is dealt with in the manner considered best adapted to meet and combat that disease. The answer to the fourth question is that the extension of the infectious disease (Notification) Act to pulmonary phthisis does not confer greater powers on Local Authorities, but enables them to ascertain where cases of the disease exist.

Dundee and Treatment of Cancer.—It is announced that the Caird Cancer Hospital will be opened in a few weeks. Arrangements have been made for three wards being occupied, while a fourth is to be set apart for electrical treatment, the apparatus having been provided by Mr. J. K. Caird, the donor of the new hospital. It is hoped that soon a laboratory for the study of cancer will be started, and towards this end Mr. Caird has generously offered to guarantee £1,000 a year for five years.

Proposed New Dispensary in Anderston, Glasgow.—As was indicated a week or two ago, the proposal to open a new dispensary in Glasgow was opposed by the practitioners in the neighbourhood on the ground that it was not demanded by the requirements of the district. An independent inquiry into the conditions by the staff of the *Glasgow Herald* has led to a similar conclusion—that the creation of a new dispensary would lead to a vexatious and wasteful overlapping of philanthropic effort.

Notification of Births in Glasgow.—The corporation has elaborated a scheme for the compulsory notification of births within forty-eight hours. It was proposed to place the obligation to do so on the physician attending, but as no provision was made for the payment of a notification fee the scheme was opposed by the profession, and the clause has been dropped.

BELFAST

BELFAST DISTRICT ASYLUM: INSPECTOR'S REPORT.—This report, just published, contains several points of interest. One is the reference to the cause of death in the patients who died during the year. These numbered 99, and in 23 cases the cause of death was verified by *post-mortem* examination. In 17 cases, or almost 17 per cent. of the whole, death was due to general paralysis of the insane, while in only 9.9 per cent. was it due to tuberculosis. These figures are very different from those found in asylums in rural districts in Ireland. There are at present 11 men and 3 women under treatment for general paralysis in the asylum. Another point of interest is the description of the new villas at Purdysburn, now in full working order. In them 400 of the total of 1,114 patients on the books of the asylum are housed, and the results are most satisfactory. The villas are comfortable houses, and every appearance of restraint is avoided. Windows and doors are freely opened, and the patients help in the ordinary domestic work, under the direction of a nurse in each villa. The general surroundings are said to be homely, and the discipline and formality of public dining-halls is entirely absent. The results in Purdysburn are evident, the patients looking far brighter and happier than they usually do, and there is no doubt that the villa treatment will be extended to all suitable cases

LETTERS TO THE EDITOR.

TRYPSIN IN CANCER.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Every medical man must deplore the frequent attempts which are made in the Lay Press to induce the public to believe that a cure for cancer has been discovered. Whenever an allegation of this kind is made it is doomed to excite false hopes in the minds of unfortunate sufferers, inasmuch as in the present state of our knowledge we are unable to promise any such consummation in the treatment of this disease.

My reason for availing myself of this opportunity of referring to the subject is based upon the facts that an article entitled "The Approaching Conquest of Cancer," purporting to deal with the treatment of the disease by trypsin, appeared in the *Pall Mall Gazette* last week, with the result that some publicity has been drawn to this question; and that last week, on December 12th, there appeared in the MEDICAL PRESS AND CIRCULAR a review of my small book on "The Nature and Treatment of Cancer" (*a*) in which you kindly say "my views on the treatment of cancer, and the work I have done on the subject, are so well known that there is no need to do more than mention that my little book has now reached a fourth edition."

What, however, is of more importance, and in contradistinction to the misleading notices in the *Pall Mall Gazette*, is your opinon that "the whole subject is still in a tentative condition, so that the wise course is still to suspend judgment; that my methods are being extensively tried (as you believe, and which I can affirm), and doubtless the experience of a few more years will decide how much of permanent value there is in them."

It seems a pity, as you, sir, have frequently pointed out, that the editors of lay newspapers and journals could not have attached to their staff a medical expert, to whom all matters of a professional nature sent to them by correspondents could be referred for instruction and guidance.

While my daily experience of the treatment of cancer by trypsin, alone or aided by other substances, continues to convince me of its efficacy in affording relief by causing an amelioration of the symptoms and in some cases actual arrest and diminution of the growth, I do not think I am justified in asserting that the treatment can be regarded as curative at the present time. It must take, and is bound to take a considerable time and many cases to arrive at any proper conclusion regarding the precise value of this treatment. Moreover, the trypsin treatment of cancer, as I have pointed out in my book, does not merely consist in the administration of trypsin or pancreatic extracts in one or other of its various preparations. I propose to publish shortly a further series of cases in which, so far, results have afforded room for the greatest encouragement.

If I presume to claim the right to speak on this subject, it is because that since the period I suggested this method of treatment I have been engaged in elaborating and placing it on a more satisfactory basis. In this connection I should like to recall to the notice of your readers the facts that I drew attention to the influence of the pancreas in cancer in the *Lancet* of January 14th, 1905; that previously to this my work was known to many and portrayed in my pamphlet, "Some Methods of Hypodermic Medication in the Treament of Inoperable Cancer" (October, 1904), also in the *British Medical Journal*, January 7th, 1905; that the treatment of cancer by hypodermic injections of trypsin and of pancreatic preparations was commenced by me on January 19, 1905, and these methods introduced to the notice of the profession in the *Lancet*, February 11th, 1905, and MEDICAL PRESS AND CIRCULAR, March 8th, 1905; that the suggestions which led me to this treatment were based on clinical and chemical considerations, and absolutely independently of any embryological work or theory.

I am, Dear Sir, yours faithfully,
J. A. SHAW-MACKENZIE, M.D. (Lond).

London, W., December 15th, 1906.

MEDICAL EVIDENCE IN THE LAW COURTS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It seems to me probable that many who followed the evidence given in the Cardiff case by the medical witnesses have, like myself, felt some difficulty in understanding how it influenced the judge and jury in the verdict thus arrived at. The way in which Mr. Rufus Isaacs cross-examined Mr. Rose must have caused much amusement, or rather the way in which Mr. Rose gave replies to the questions that were put to

(*a*) "The Nature and Treatment of Cancer." By John A. Shaw-Mackenzie. M.D.Lond. Fourth Edition, revised. London: Bailliere, Tindall, and Cox. 1906.

him. In everyday conversation we experience the great difference there is between questions asked us by an ignorant and more or less prejudiced person, from those which the expert or the anxious inquirer may put to us. In matters medical every one almost has an opinion founded on some personal experience, or what has been learnt from others, and there is far less confidence placed on the advice and opinions of medical practitioners than upon those of the lawyers on matters of legal interest, though these very subjects are so much easier for ordinary persons to understand. We do not see lawyers put into the witness-box as doctors are, to give their views of the meaning and intentions of our laws, though we do see curious differences in the conclusions arrived at on the same case in different courts. It is probable that the old-fashioned course of "Lectures on Forensic Medicine," which was one that had to be signed up for in the late stage of hospital studies, was intended to prepare practitioners for the kind of evidence they might have to give in Law Courts, and the care they should observe in giving it. Now this kind of work is handed over to experts, and medical evidence of the ordinary practitioner is limited to the special details of the case in hand. It is usual, it may be noticed, in the cross-examination of the medical witness personally concerned, for questions to be chiefly asked, not on the actual facts stated in regard to the case itself, but upon the various theories or views held in the profession on the class to which the case belongs. And then, when experts are put into the box no questions are put upon the statement regarding the special case, for the simple reason that it has not been under their care; but the questions asked all bear on the views of this party or that in the profession, and the extent to which the injuries complained of may have arisen from ignorance or culpable neglect. In the Cardiff case some surprise must have been felt that such a strong array of expert evidence on the defendant's side should have apparently had but little influence on the jury, and the question arises whether it would not be far better to do away with expert evidence called by each side, and let one or more independent medical witnesses be appointed by the Court to give evidence, as is done in cases of lunacy when brought under the Lord Chancellor.

It is so natural that a hospital teacher should feel a personal interest in a plaintiff or defendant with whom he is more or less personally acquainted as an old pupil or friend, and consequently his evidence may not be altogether that of an unbiassed expert. In this age of reform let us hope that we shall see before long some improvement in the way in which medical evidence is conducted in our courts of law.

I am, Sir, yours truly,

A Former Lecturer on Forensic Medicine.

Pwllheli, North Wales.

THE GENERAL MEDICAL COUNCIL ELECTION

To the Editor of The Medical Press and Circular

Sir,—Will you permit me to express my gratitude to every one of the 1785, whether lady or gentleman, who has taken the trouble to vote for me, and to say that I do not regret having taken part in the fray; that many happy incidents have occurred, especially communications from old friends all over the country, and that the result will have no deterrent effect upon my efforts for the union and interests of the profession generally, and that I am glad to have had the opportunity of placing so prominently before the profession my views on essential matters in medical politics. It is just possible that organisation has carried the day rather than sound views without it. We in the north are perhaps too happy in our independence. Above all I must express my thanks to the medical press generally for the liberal grant of space, both for my friends and myself.—I am, sir, yours truly,

G. H. Broadbent.

Manchester, Dec. 12th, 1906.

To the Editor of The Medical Press and Circular.

Dear Sir,—I will thank you to permit me through your valuable columns to express my gratitude to the 3773 medical practitioners who during the election just concluded, recorded their votes in my favour. My thanks are specially due to those who have voluntarily worked for me for several weeks past in the hope to secure my re-election. I must confess to feeling disappointed at the result, as I had hoped that the recollection of past services—ten years as a medical councillor—would have had greater influence when voting papers were before the electors, but I am cheered by the reflection that more can be done for the profession and the public as a "free lance" than would be possible if wrapped in the constricting robes of a medical councillor. I have long felt that the battle of medical reform must be fought outside the Council Chamber. Again thanking you for your courteous indulgence,

I am, sir, yours truly,

George Brown.

Callington, Cornwall, Dec. 12th, 1906.

To the Editor of The Medical Press and Circular.

Sir,—Will you allow me, through your columns, to thank the profession in Scotland for the great honour it has done me in electing me as its Direct Representative on the General Medical Council. It shall be my earnest endeavour to warrant the confidence.

I am, Sir, yours truly,

Norman Walker.

Edinburgh, December 10th, 1906.

A NOTE ON THE ELECTION FIGURES.

Sir,—The number voting, whose votes were valid, is 10,249; and the highest number of votes given to any one is 4,861. That is, the successful candidates were elected by fewer than half of those voting. Under *Proportional Representation* one of the first three would have been elected and perhaps a second. For the second three the number of votes equals 10,247, so that one third of the voters would have elected one of the second three. I assume that the same voters voted for all the first three, and likewise for the second three. The votes given to the remaining four are thrown away. Their number is 5,741, or one-half nearly of all the voters. It would have been possible for one of them to be returned, instead of one of the first three, but perhaps unlikely. This is not by way of suggesting that the selected are not well worthy of our confidence. Not at all. But the figures invite consideration whether the election is as representative as it might be made.

I am, Sir, yours truly,

G. Crichton.

Lexham Gardens, Kensingtan, W.

Dec. 15th, 1906.

MEDICAL ASSISTANCE TO MIDWIVES.

To the Editor of The Medical Press and Circular

Sir,—I am directed by a Committee of the London and Counties Medical Protection Society, which is considering certain matters affecting the interests of medical practitioners, and arising out of the working of the Midwives Act, to invite members of the medical profession to assist by giving information individually on the following points:—

1. The number of instances, in a given time, in which each medical man has been summoned to the assistance of midwives, sending for him in pursuance of the rules of the Midwives Board.

2. What payment he received in each case, and from whom?

3. What was the nature of each case to which he was so summoned?

Will you kindly allow me to ask your readers to be good enough to send answers to the above questions, authenticated by the name and address of the sender, to me at the offices of the Society, 31, Craven Street, Strand, London, W.C.

I am, sir, yours truly,

Hugh Woods,

General Secretary.

THE MOUTH AS A FOCUS OF INFECTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It seems a pity Dr. F. Norman did not point out in his excellent paper published this week that it is impossible to treat satisfactorily a mouth which is a focus of infection without the assistance of a dental surgeon. This remark applies especially to pyorrhœa alveolaris. The only effectual way to deal with the "pockets" around the teeth after removing the tartar, is to apply antiseptics direct to the parts. A patient cannot do this for himself, neither can it be done effectually by an unskilled operator. The *modus operandi* will be found described in dental text-books—very clearly in Sewill's manual. Perchloride of mercury and other powerful germicides may be thus used. Septic mouths among all classes of patients have increased in number with the growth of quack dentistry. The number of cases in which "bridge work" may be properly used is really very small. Artificial teeth fixed irremovably always cause extreme sepsis unless the remaining natural teeth and stumps be first brought into a perfectly healthy condition. The quack disregards this consideration, and often leaves roots, the causes and centres of suppuration, to lie hidden under the frames. Close examination of the mouths of many wealthy (often foolish) women, the victims of quackery, would often reveal to the medical attendant a state of things needing to be reckoned with both in diagnosis and treatment. Among the poorer classes it will frequently be found that a plate and clasps, composed partly or entirely of inferior metal, with still lower quality solder, is worn over fœtid stumps, and rarely removed for cleansing. The galvanic action of the metals aggravates the condition, and this is often bad enough to excite local disease, and to affect seriously the general health.

I am, sir, yours truly,

A HOSPITAL DENTIST.

London, W., Dec. 14th, 1906.

OBITUARY.

RICHARD SKINNER FOWLER, F.R.C.S.Edin., M.R.C.S.Lond., OF BATH.

One of the most popular medical practitioners of Bath died on the 9th instant. in the person of Mr. Richard Fowler, at the age of 76. In recognition of his services in the small-pox epidemic of 1858, the working men of Bath, to the number of 1,500, presented him with a testimonial and a purse of sovereigns. Mr. Fowler was born in Bath in 1830. Then, in January, 1855, he became house "apothecary" or house physician, at the Royal Bath United Hospital, and this office was his until March, 1859, the year after the small-pox epidemic just referred to, and in connection with which Mr. Fowler worked heroically in the special hospital. Then he sought private practice, and in 1867 was elected hon. surgeon. He resigned in December, 1890, and was then made hon. consulting surgeon, and in January, 1904, he was elected to fill the office of president. For 24 years Mr. Fowler was surgeon to the 1st V.B. Somerset L.I. Other positions which Mr. Fowler held included the vice-presidency of the Royal Medical College at Epsom; he was an honorary life governor of the Jews' Society; and a trustee of the Blue Coat School since 1894.

DAVID McKEOWN, M.D., R.U.I.

We regret to announce that Dr. McKeown, of Manchester, honorary medical officer of the Manchester Eye and Ear Hospital, died suddenly on Sunday week at Chinley, where he had been staying for the benefit of his health. He was 55 years of age. Deceased was a distinguished student of Belfast, and graduated M.D. Royal University of Ireland, with honours, in 1877.

JAMES PAUL RUDOLF LAMBERT, M.D.Edin.

We regret to record the tragic death of Dr. James Paul Rudolf Lambert. He was dragged under a railway carriage at South Kensington station and received such terrible injuries that he died an hour later at St. George's Hospital. By an irony of fate the station officials sent to his own house to summon him to attend the injured man. Deceased graduated M.D. of Edinburgh University in 1895, and M.B. in 1890.

ALEXANDER WAUGH, M.R.C.S.Eng., L.R.C.P.

We regret to record the death of Mr. Alexander Waugh, of Midsomer Norton, on December 9th. Dr. Waugh was born at Warminster on October 15th, 1840, and was, therefore, just over 66 years old when he died. His father, the Rev. James Hay Waugh, was rector of Corsley, Wiltshire. On leaving Radley College, he entered the Bristol Medical School, where he graduated from, and afterwards took his degrees at St. Bartholomew's Hospital. He lived in Midsomer Norton for 41 years, and was identified with every side of the life of the town. In 1880 he was elected president of the Bath and Bristol branch of the British Medical Association, being at that time the youngest man ever elected to that honour. He was for many years medical officer of health; and was conspicuously identified with the local improvements effected by the Local Board. Dr. Waugh was as popular in private life as in public. He was a keen sportsman, a fine shot, and an enthusiastic fisherman, and loved every form of manly recreation.

JAMES GRAY, M.A., M.D.Edin., F.R.C.S.Edin.

The death is announced of Dr. James Gray, one of Dundee's most promising surgeons, at the early age of 34. His end came suddenly, following upon blood-poisoning two years ago. Dr. Gray graduated M.A. at St. Andrews in 1892. The first two and a half years of his medical course were spent in Dundee. He obtained in 1895 the degrees of M.B. and C.M. at Edinburgh University with honours. Three years later Dr. Gray was elected a Fellow of the Royal College of Surgeons, Edinburgh. After graduation Dr. Gray was appointed junior demonstrator of surgery in Edinburgh University. When he returned to Dundee it was to take up the position of assistant to the Professor of Surgery in University College, and during the vacancy in the Professorship of Pathology in the College Dr. Gray acted as interim lecturer on practical pathology. In May, 1899, Dr. Gray entered into private practice, and until recently he was medical officer for the middle dispensary district in connection with Dundee Royal Infirmary, to which appointment he was elected in 1900. Five years ago he was appointed an assistant surgeon in Dundee Royal Infirmary.

GIUSEPPE LAPPONI.

On Friday, December 7th, at 6.20 a.m. died the Pope's body physician, Dr. Giuseppe Lapponi, who had acted in the same capacity to the Pontiff's immediate predecessor Leo XIII. Born at Tolentino in the Marches on April 16th, 1851, he was but 55 years old when he succumbed to an illness of some three years' standing—an illness obscure in its earlier stages, but latterly declaring itself as carcinomatous in character, affecting the liver and finally the spleen. With the energy and devotion to duty which belonged to him he remained at his post long after it was wise or prudent in him to do so—till, in fact, his distinguished patient had plainly to tell him that, of the two, the doctor was most in need of medical aid. He continued, however, his periodical visits within a few days of each other at the Vatican, so far yielding to the Pope's kindly insistence as to take to bed immediately afterwards. But the end was not distant, and on the morning of December 3rd, on returning from a short drive, he was seized with acute rigors, coincident with a raised temperature. Dr. Marchiafava and Dr. Gallenga, who attended him, found him in the initial stage of bilateral pleuro-pneumonia, and from the first, though unremitting in their care, took the most desponding view of his case. An apparent rally on the Thursday (the 6th. was not maintained, and he sank rapidly, while pre-

serving the clearness of his faculties, till, as stated, he passed away in the early morning of the 7th, his wife, his son, his daughter, and Dr. Gallenga being at his bedside.

RICHARD WILLIS, M.R.C.S.Eng., L.S.A.

We regret to announce the death of Mr. Richard Willis, at his residence Horrabridge, Devonshire, on December 4th, from pneumonia, following influenza. Deceased, who was the son of the late Mr. John Willis, of Plymouth, received his medical education at Guy's, and qualified M.R.C.S.Eng. in 1842. Mr. Willis shortly afterwards settled at Tavistock, and had the largest practice in the district. He was for many years a member of the Tavistock Board of Guardians and other local bodies. He retired from active practice some years ago, and took up his residence at Horrabridge, where he died in his 87th year.

NEW BOOKS AND NEW EDITIONS.

APPLETON, SIDNEY (London).
The Prophylaxis and Treatment of Internal Diseases. By F. Forchheimer, M.D. Pp. 632. Price 21s. net.
Operative Gynæcology. By Howard A. Kelly, A.B., M.D., &c., &c. Illustrated. 2 vols. Pp. 1336. Price £3 3s. net.
A Text-book of Human Physiology. By Dr. Robert Tigerstedt. Translated and Edited by John R. Murlin, A.M., Ph.D., with an Introduction by Prof. Graham Lush, Ph.D., F.R.S.Edin. Illustrated. Pp. 751. Price 21s. net.

ARNOLD, EDWARD (London).
The Chemical Investigation of Gastric and Intestinal Diseases by the Aid of Test Meals. By Vaughan Harley, M.D.Ed., &c., &c., and Francis W. Goodbody, M.D., M.R.C.P. Pp. 261. Price 8s. 6d. net.

BAILLIERE, TINDALL AND COX (London).
Aids to Medical Diagnosis. By Arthur Whiting, M.D., M.R.C.P. Pp. 152. Price 2s. 6d. cloth, 2s. paper.

BAILLIERE ET FILS (Paris).
L'Obésité et son Traitement. Par P. le Noir. Pp. 96.

BALE, SONS, AND DANIELSSON, LTD. (London).
Pulmonary Phthisis; its Diagnosis, Prognosis, and Treatment. By H. Hyslop Thomson, M.D. Pp. 188. Price 5s. net.

CHATTO AND WINDUS (London).
Herbert Fry's Royal Guide to the London Charities. Edited by John Lane. 43rd Edition, revised. Pp. 383. Price 1s. 6d.

CHURCHILL, J. & A. (London).
Reports of the Society for the Study of Diseases in Children. Vol. 6, 1905-1906. Edited by George Carpenter, M.D. Pp. 324. Price 12s. 6d. net.

FROWDE, HENRY (London).
The Growth of Truth as Illustrated in the Discovery of the Circulation of the Blood. By Wm. Osler, M.D., F.R.S. Pp. 44. Price 1s. net.

HADDEN, BEST AND CO. (London).
Hadden's Pocket Vocabulary of Medical Terms. By Henry Payne, M.D., &c. Fourth Edition, revised and enlarged. By Philip Cowen, M.D., and Herbert Davey. Pp. 229.

HARRISON AND SONS (London).
Glimpses of American Surgery in 1906. By C. Hamilton Whiteford, M.R.C.S., L.R.C.P. Pp. 63. Price 2s. net.

LEWIS, H. K. (London).
The Bacteriological Examination of Water-Supplies. By William G. Savage, B.Sc., M.D.Lond., D.P.H. Pp. 297. Price 6s. 6d. net.
A Handbook of Diseases of the Eye and their Treatment. By Henry R. Swanzy, A.M., M.D., and Louis Werner, M.D., F.R.C.S.I. Ninth Edition. Illustrated. Pp. 744. Price 12s. 6d.

J. B. LIPPINCOTT CO. (London).
Post-mortem Pathology. By Henry W. Cattell, A.M., M.D. Third Edition, illustrated. Pp. 547. Price 18s. net.

LONGMANS, GREEN AND CO. (London).
School Hygiene and the Laws of Health. By Charles Porter, M.D., &c., &c. Illustrated. Pp. 313. Price 3s. 6d.
Transactions of the Clinical Society of London. Vol. 39. Pp. 272.

MACMILLAN AND CO., LTD. (London).
Studies in the Bacteriology and Etiology of Oriental Plague. By E. Klein, M.D., F.R.S. Illustrated. Pp. 301. Price 12s. net.
A System of Medicine. By Many Writers. Edited by T. C. Allbutt, M.A., M.D., &c., &c., and Humphry D. Rolleston, M.A., M.D., &c. Vol. 2. Part 1. Pp. 1087. Price 25s. net.

MURRAY, JOHN (London).
Cancer of the Breast and its Operative Treatment. By W. Sampson Handley. Pp. 232. Price 12s. 6d. net.

PENTLAND, YOUNG J. (Edinburgh).
Manual of Surgery. By Alexis Thomson, F.R.C.S.Ed., and Alexander Miles, M.R.C.S.Ed. Vol. 1. General Surgery. Second Edition, revised, enlarged and illustrated. Pp. 808.

SCIENTIFIC PRESS, LTD. THE (London.)
The Nurse's "Enquire Within." By C.O.M. Pp. 166. Price 2s. net.

SHERRATT AND HUGHES (Manchester).
Polypus of the Nose. By Eugene S. Yonge, M.D.Ed. Pp. 174. Price 2s. 6d. net.

SPOTTISWOODE AND CO., LTD. (London).
Mountain Sickness and its Probable Causes. By T. G. Longstaff, M.A., D.M. Pp. 56. Price 1s.

VINTON AND CO., LTD. (London).
Live Stock Journal Almanac, 1907. Illustrated. Pp. 344. Price 1s.

REVIEWS OF BOOKS.

SAVILL ON NEURASTHENIA. (a)

ONE takes up a work on neurasthenia with a certain misgiving. The subject has been so mauled by irresponsible writers who contributed nothing original to our knowledge of this protean malady that one despaired of further light being thrown on its etiology—and it is the etiology that matters, because there can be no sound treatment until this problem has been unravelled.

Now the author really does attempt something in this direction, and his arguments are not merely "views," since they are based on an imposing number and variety of personal observations. To him, we believe, belongs the credit of pointing out the connection between the condition known as neurasthenia and certain toxic states of the blood, though this was for a long time hotly contested by admitted authorities. Now a fertile source of "toxic blood states" is to be found in the gastro-intestinal tract, and disturbances of function in this area were forthwith incriminated by the author as the original source of the depressing toxins. In the present edition he goes even further, and, by very painstaking investigation of a series of private cases, has analysed the relative frequency of various toxic conditions in the production of neurasthenia.

The importance of this departure will be recognised if we bear in mind that, hitherto, physicians have for the most part been content to treat the functional derangement of the nervous system—neurasthenia—by rest, psycho-therapy and other measures empirically directed to the improvement of the nervous symptoms—in short, by symptomatic treatment. Dr. Savill, on the contrary, aims at the identification of the cause, with a view to its preventive and curative treatment. This gives his work the stamp of originality, and will secure for him a sympathetic reception from practitioners. The scope of treatment is thus considerably enlarged and its chances of success correspondingly increased. The author provides us with well-thought-out schemes of treatment, each adapted to the particular etiological variety, and for that we cannot but be grateful. It is emphatically a practical guide to the treatment of neurasthenia, based on a solid foundation of direct observation.

New System of Hospital Accounts.

A CIRCULAR of much importance to medical charities employing what is known as the uniform system of hospital accounts has been recently issued jointly by King Edward's Hospital Fund, the Hospital Sunday Fund, and the Hospital Saturday Fund. The statistics now required from hospitals applying for grants has brought to light various defects, and the whole subject of hospital accounts was reported on at the Prince of Wales's request by Mr. J. G. Griffiths, F.C.A., last year. This report was subsequently referred to a committee of hospital secretaries, presided over by Mr. Ryan, of St. Mary's Hospital. The three Funds have now issued an official statement containing particulars of the revised system, which will come into force on January 1st next, and which all institutions applying for grants from these Funds will be required to adopt. The circular contains, in addition to the form of income and expenditure account, a model balance-sheet and statistical tables, with a full index of classification, giving the headings under which the various items of expenditure are to appear. Full explanations of the changes in the old system are supplied. Copies may be obtained from the publisher, Mr. G. Barber, 23, Furnival Street, E.C., price 1s. post free.

(a) "Clinical Lectures on Neurasthenia." By Thomas D. Savill, M.D.Lond., Physician to the West End Hospital for Diseases of the Nervous System, Assistant Physician to the West London Hospital. Third Edition. London: H. J. Glaisher. 1906.

MEDICAL NEWS IN BRIEF.

Royal College of Surgeons of England.

AT an ordinary meeting of the Council of the College held on Thursday last, Mr. Henry Morris, President, in the chair, the congratulations of the Council were given to Sir John Tweedy, the late President, upon receiving from his Majesty the honour of Knighthood. A vote of thanks was passed to Mr. and Mrs. Bischoffsheim for their munificent gift of £40,000 to the Imperial Cancer Research Fund.

The Standard of Preliminary Education.—The resolutions passed at the recent meeting of Fellows and Members relating to the questions of admitting members to direct representation on the Council and admitting women to the College examinations were considered and are still under consideration of the Council. With regard to the third resolution passed at the same meeting relating to the raising of the standard of the Preliminary Examination in General Education and in Science, and the treating of chemistry, physics, and biology as matters of preliminary education, the Council decided to submit the following observations for the information of the Fellows and Members:—

The Standard of General Education.—With regard to the suggestion that the standard of the examination in general education be raised, the Council would remind the Fellows and Members that, so recently as 1900, steps were taken with this object. From the beginning of that year the General Medical Council ceased to recognise, for the purpose of registration, the first division Second Class Certificate of the College of Preceptors. As pointed out by the Council in their report to the Fellows and Members in 1901, a decrease of 305 in the number of students registered during the year after passing the examinations of the College of Preceptors immediately ensued upon this alteration, while an increase of 40 in the number of students registered after passing the Preliminary Examination of the Educational Institute of Scotland was noted; In view of these facts the Council think that, so far as this division of the United Kingdom is concerned, it would be inexpedient at the present time to still further increase the difficulty of the examination in general education.

Again, as regards the suggestion that the standard of the Preliminary Examination in Science should be raised, the Council would remind the Fellows and Members that in this matter steps have been taken even more recently. During the years 1903 and 1904 the Council, in association with the Royal College of Physicians, devoted much time and attention to the regulations relating to the first year of the medical curriculum and the examination in the subjects of Chemistry, Physics and Biology studied during that period. After consultation with the teachers in those subjects at the several medical schools in England, and the past and present examiners, revised regulations, effecting a complete re-arrangement of the examination, and materially raising its standard, were adopted. These regulations came into force in March, 1905.

With reference to the opinion that Chemistry, Physics and Biology should be treated as subjects of preliminary education and an examination be passed in them before the commencement of medical studies, the views of the Council upon this question, and their reasons for forming them, are fully set forth in the last annual report of the Council.

The thanks of the Council were given to Sir Victor Horsley, F.R.S., for his very interesting and valuable report upon the brain of Professor Babbage, a specimen in the museum of the college.

The Museum Committee reported that Vol. III. of the revised edition of the Physiological Catalogue was now ready for press, and it was decided to publish it with illustrations. The Committee was also authorised to consider and report as to what steps it is desirable to take with a view to preparing a new edition of the Pathological Catalogue.

A report was received from the Committee of Management submitting recommendations in regard to the examinations of the London School of Tropical Medicine.

"Peculiar People" and their Child:

AT Grays Police Court on December 7th, William Thomas Clark and Jane Clark, members of the "Peculiar" People, Grays, were charged with the manslaughter of their daughter Emily, aged seven. Herbert Henry Carter, an elder of the "Peculiar People," was charged with aiding and abetting.—Mr. Donald Maclean, M.P., who prosecuted on behalf of the National Society for the Prevention of Cruelty to Children, stated that Clark saw Dr. Ward and asked him to examine the throat of the child, who was found to be suffering from diphtheria. Clark said he did not want the child medically treated. The doctor advised medical treatment, and that the child be sent to hospital. Clark hesitated, and said he would let him know in two hours. Subsequently he went to the doctor's surgery with Carter. The doctor was informed that it had been decided not to send the child to hospital, and an antiseptic for the throat was also refused. The child died from heart failure produced by diphtheria. If properly treated, said counsel, the child's life would probably have been saved, as the case was of ordinary severity. Whilst the child was ill Carter anointed her and prayed over her, and it was submitted that Carter, by his position, influenced the two other defendants with regard to medical aid. After a lengthy hearing the defendants were committed for trial at the next assizes. Carter stated that he had helped the parents out of sympathy, and had not influenced them in any way.

Employment and Disease.—The Insurance of the Worker.

BEFORE the Insurance Society of Manchester last week. Dr. Dearden read a paper on "Diseases of Occupation from an Insurance Standpoint." Dr. Dearden recognised that, broadly speaking, industrial disease should cover any illness in the causation of which the trade of the patient was a factor, but to include all cases which came within this definition as qualified for compensation would, he thought, lead to injustice in some cases, imposition in others, and the expenses of litigation in most. It would be better to go in wholly for the German system than to attempt such a course. The difficulties of deciding such cases as whether a man contracted bronchitis or consumption in the exercise of his work or otherwise would be insurmountable. There were, however, certain definite dangerous trade processes with respect to which the risk of illness was very well understood, and concerning which the symptoms attributable to the particular noxious elements were well defined. The people engaged at these processes were just as much entitled to compensation when made ill through working at them as if they were the victims of accident. Why should these people be deprived of that to which they were entitled because of the difficulty of assessing the extent of responsibility of employer and employed in cases concerning which our knowledge was not so exact? It was quite possible, he thought, to avoid a definition of insurable industrial disease altogether, and simply schedule a list of diseases arising out of well-understood trade processes. He pointed out that the present Government had included in the Workmen's Compensation Bill provision for compensation on the occurrence of disease caused by certain sche-

duled processes, and he thought a great deal of good would accrue from the Bill if it passed into law. The Factory Acts had to be built up gradually to their present pitch, and so would these dangerous trades regulations. That the Government intended to do all it was possible to do to place other industries on the schedule was evidenced by the appointment of a departmental Committee to report on the matter.

Polyclinic Dinner.

The eighth annual dinner of the Polyclinic took place at the Trocadero last Wednesday, and in the number of diners, the distinction of the guests, and the vivacity of the proceedings, it was well up to the level of former years. The dinner committee were fortunate in obtaining Professor Clifford Allbutt for the chairman, for his name is sufficient in itself to attract all those who have the interests of medical education at heart. Mr. Henry Morris, as President of the College of Surgeons, was on the chairman's right, and Sir Alfred Keogh, K.C.B., on his left. Other well-known members and guests present were Sir Felix Lemon, Dr. Theodore Williams, Surgeon-General Branfoot, Dr. Dundas Grant, Mr. Malcolm Morris, Mr. Bidwell, Mr. Mayo Collier, Dr. Fletcher Little, Mr. James Cantlie, Dr. James Taylor, Mr. Keetley, Mr. Marcus Gunn, Mr. MacLeod Yearsley, and Captain Hayward Pinch, the Secretary. A number of ladies were present, some of them members of the Polyclinic, and some guests. After a particularly well-chosen and well-served dinner, the chairman gave the usual loyal toasts, and proceeded to propose the success of the institution in support of which the evening had been organised. Professor Allbutt dwelt chiefly on the advantages of post-graduate teaching, especially when divorced from elementary teaching. He praised the old method of instruction by disputation, and hoped that as far as convenient it would form the model on which the post-graduate classes were conducted. As head of a medical school almost purely scientific in its curriculum, he felt more and more the value of well-founded empiricism, and he urged all students of the Polyclinic to force to the front the facts and deductions they had gathered at the actual bedside of patients. The pathologist, he concluded, dealt with organs and tissues irreparably damaged; the finest practitioner was he who recognised disease in its early manifestations, and nipped them in the bud. Captain Pinch, in replying, pointed out that it cost a man two-thirds of a penny a day, or fourpence a week, to belong to the Polyclinic. There was no better investment in the profession. Mr. Cantlie, in a breezy speech, proposed the guests, for whom Mr. Morris and Sir Alfred Keogh replied. The final toast was that of "The Chairman," given by Dr. Theodore Williams. Vocal music was emitted at intervals during the evening.

An Action Settled.—Lady and Hydropathic Establishment.

In the King's Bench Division, last week, Mr. Justice Grantham had before him an action brought by Mrs. Merton, of Hans Crescent, South Kensington, against Dr. Ferguson, of a hydropathic establishment at Great Malvern, to recover damages. Mr. Montague Lush, K.C., for plaintiff, after a lengthy consultation between the judge, counsel, and the parties, said he was glad the parties had been able to come to a settlement. The action was for damages for a very heavy loss sustained by plaintiff. Mrs. Merton and her two sons, who were attending Eton, went to the hydropathic establishment of Dr. Ferguson, at Great Malvern, and while there contracted typhoid fever. One of her sons died as a result. The amount of plaintiff's out-of-pocket expenses was £1,250, and that amount had been paid by defendant into court, and he had also agreed to pay taxed costs. Mrs. Merton was now willing that the case should terminate, her desire to call public attention to the dangers run by the public having been effected. Mr. M'Call, K.C., for defendant, said he also was glad they had been able to avoid such an inquiry, which must of necessity be of a painful and profitless character; but he must say that his client was not directly responsible in this matter. What happened was due to the negligence of others, and that would be a question to be tried hereafter. His Lordship entered judgment for plaintiff with costs.

Cancer Research in Dundee.

Through the gift of a new building primarily intended for the purposes of a cancer hospital the accommodation in Dundee Royal Infirmary will be increased 50 per cent. The donor is Mr. J. K. Caird, LL.D., jute manufacturer, and the intention is that three of the wards should be occupied by patients, while in the fourth apparatus, also provided by Mr. Caird, will be fitted for the electrical treatment of patients. The directors have also a project in hand for cancer research, and towards this scheme Mr. Caird has guaranteed £1,000 a year for five years.

Anthrax in Liverpool.

A second death from anthrax, occurring within a week, was recently investigated by the Liverpool coroner. Joseph Henry Tomlinson, a dock labourer, æt. 28, had been working in the hold of an American liner, assisting in the storage of bales of dry hides en route from Rangoon to New York. On Thursday he received a scratch on the shoulder, caused by a nail, and next day, after working among the hides, he complained of pain. His wife applied a poultice to the scratch, which had become inflamed, and a doctor was summoned, who pronounced the man to be suffering from anthrax. An operation was performed in hospital, but the man died next day. A question being raised as to the use of gloves for handling hides, it appeared that regulations as to anthrax were posted up at the dock, and the steamship company had formerly distributed gloves among the men, but these were gradually discarded, and now it was left to the men to ask for them if they preferred to use them. In future the men would be required to use gloves when handling hides and skins. A verdict of "Death from anthrax" was returned.

A Medical Man sent to Penal Servitude.

Arthur Raynor, 57, physician, indicted at the Central Criminal Court on December 12th, for using an instrument, or certain means unknown, with intent to procure the miscarriage of Anne Lilian Martin, was sentenced to three years penal servitude by Mr. Justice Lawrance.

Royal College of Surgeons of England.

The following members of the college, having passed the required examinations and conformed to the bye-laws were admitted Fellows of the college:—Edward H. Douty, M.R.C.P., Lond., William J. Richards, L.R.C.P., Lond., Hugh M. Davies, L.R.C.P., Lond., Arthur de Silva, L.R.C.P., Lond., Alfred Ed. Johnson, M.B., Vict., Gwynne E. O. Williams, M.B., Lond., William Taylor, M.B., Lond., Bernard B. Riviere, L.R.C.P., Lond., Henry Gilbert, M.B., Melb., Harold P. Gibb, L.R.C.P., Lond., Robert F. Moore, L.R.C.P., Lond., Ernest C. Hughes, L.R.C.P., Lond., Harold T. Mant, M.B., Lond., Robert Milne, M.B., Lond., Walter W. Moore, M.B., New Zealand Univ., Reginald A. Greeves, M.B., Lond., Percy K. Steele, M.B., Vict.

Diplomas in Dental Surgery were granted to the following candidates:—Matthew Alexander, Arthur R. B. Allen, Albert E. S. Austin, Francis W. Bartle, Russell Beadnell-Gill, Frederick A. Beckley., Howard D. Clapham, Samuel S. Cooper, Edward L. Councell, Gwilym L. Davies, John R. D. Ditch, John H. R. Edward, Gordon Fryer, George B. Geake, Frank Giles, John P. Glassington, Trevor Griffiths, John E. Hanna, Edgar E. Houghton, Percy Howard, Arthur E. Ironside, Herbert E. Jackson, Charles E. Lloyd, Maurice J. Maguire, Ivor Margolies, Herbert R. Mays, Claude Miller, Frederick C. Nichols, Reginald J. Oliver, George Packham, Arthur H. Pickett, Ronald R. B. Ponder, Edmond L. Renton, Norman V. H. Riches, Oscar J. Roots, Walter D. Southern, Norman Y. Tessier, James G. Townsend, Gladstone Warren, Bargrave Weaver, Stephen J. Wright.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT GYNÆCOLOGICAL AND OBSTETRICAL LITERATURE

The Prophylaxis of Puerperal Eclampsia.—Hardie (*Jour. Obst. and Gyn.*, November, 1906).—The writer first mentions the familiar premonitory symptoms and signs—headache, vomiting, giddiness, and œdema of the ankles, while, if convulsions are impending, there are more pronounced cerebral symptoms, œdema of the face, and severe epigastric pain. We inquire about the urine, and find that it has been scanty, that it has a variable specific gravity, and that albumen is present. True, albuminuria is said to be sometimes absent, though personally I have never failed to find it, and this corresponds with the experience of Jardine. On the other hand, it does not follow that albuminuria necessarily leads to eclampsia, or that the actual amount present is of much prognostic significance, as the albuminuria and severity of the eclampsia are not co-related in any constant manner. It is specially needful when albuminuria is present to ascertain the quantity of urine passed in 24 hours. This is valuable in its relation to the specific gravity and amount of urea and urates excreted, for while the specific gravity may be apparently high enough, it is really low for a concentrated urine. The higher it is the more hopeful the outlook, as it indicates a larger excretion of urinary salts. The presence of blood and granular casts is, of course, of great importance. As preventative measures, much may be done during the early months of pregnancy by taking outdoor exercise, a glass of cold water night and morning in addition to ordinary fluids of the day. Cold bathing every morning during the summer months, at least; but towards the end of pregnancy warm baths are to be preferred. The bowels should be moved daily, and in the last two months of pregnancy only one nitrogenous meal should be allowed in the day. Should there be any indication of renal insufficiency or other premonitory symptoms —(a) In an early stage (subacute toxæmia), reduce the intake of nitrogenous foods and substitute fish and fowl for butcher's meat and eggs, reducing at the same time the amount of farinaceous foods. A glass of water is given four times daily between meals. Should the albumen increase under this diet, the patient is kept on skimmed milk and farinaceous foods alone, together with fresh fruit and vegetables, and rarely in obstinate cases the farinaceous foods are omitted. Drugs play but a very secondary part. The necessity for diuretics depends on the amount of urine passed, the citrate and acetate of potash being the best. To aid the metabolism of nitrogenous substances by thyroidin administration sometimes gives brilliant results and sometimes negative; the daily evacuation of the bowels should be regulated by aperients. (b) In the late stage (acute toxæmia). First in importance comes the withdrawal of food altogether, including milk, for from 24 to 48 hours, water alone being given, and where there is not much œdema, in large quantities, saline injections into the rectum are also given; unless the œdema is marked, Epsom salts are given in drachm doses every hour until a free evacuation occurs, and the acetate and citrate of potash as diuretics. The question next arises, should labour be induced? It is certainly better not to induce it for at least 36 hours, because the uterine contractions of labour might precipitate the convulsions.

F.

Early Tubal Gestation.—R. Hamilton Bell (*Jour. Obst. and Gyn.*, December, 1906).—This paper is based on the writer's experience of tubal gestation obtained from a record of 88 cases. An abstract of each case is given, and the following conclusions as to diagnosis and treatment are drawn. The diagnosis of tubal gestation, followed by tubal rupture or tubal abortion, is by no means rosy, and a number are regarded as cases of peritonitis or inflammation and abortion. In a woman between 20 and 40, after missing one or two menstrual periods, a very important symptom is abdominal pain, situated in one of the lower quadrants of the abdomen, sudden in onset, and severe in type—so severe, indeed, as to be commonly associated with faintness, or vomiting, or both. Concurrently with the pain, or shortly before, or shortly after, vaginal hæmorrhage begins, and continues irregularly day by day. The amount is small, the colour is dark, and is so characteristic as to be almost pathognomonic. Sometimes a definite cast of the uterus is passed, and in many cases there is later a slight pyrexia, and there may be difficulty with micturition. If rupture of the tube has occurred, with great internal hæmorrhage, there will soon be signs of excessive bleeding; but in the great majority of cases, whether of rupture or of abortion, the hæmorrhage is only sufficient to produce a pelvic hæmatocele. The characteristic physical signs of this condition are that the uterus is pushed forwards, and perhaps a little to one side, cervix softened, and body of uterus slightly enlarged, and that behind it, and probably more to one side than the other, is an elastic swelling depressing Douglas's pouch and the vaginal roof, and varying in consistence and tenderness. The table shows that no reliance can be placed on a history of sterility. Passing to treatment, the table shows that the surgical and not the expectant treatment has been adopted almost exclusively when the diagnosis was certain, or nearly certain. Contrasting the results obtained with those of a neighbouring observer who adopted the expectant treatment as far as possible, 83 per cent of abdominal sections gave a total mortality of 3.4 per cent., as against 9.3 per cent. in the latter series, where the percentage of abdominal sections was only 34.7.

F.

The Treatment of Inflammatory Tumours of the Adnexæ is considered by Steffock (*Münchener Med. Woch.*, 1905, No. 50). He deals first with the conservative treatment, and then with the operative. For the latter he recommends the vaginal route, by which (a) incision (b) extirpation of the adnexæ alone, or (c) extirpation of the uterus and adnexæ, or of the uterus alone may be performed. The first procedure is indicated by tumours of the tubes only in young women. The second, when old chronic tubo-ovarian tumours are present, and the technique is as follows: Anterior colpotomy through which the uterus is drawn forwards. Separation of the tumours from the adhesions, removal of the tumours, which may be opened if necessary. In this way one does not operate in the dark. After 80 such operations, the author had only one death, and this was not due to the operation. The removal of the uterus must be reserved for those cases in which both the uterus and adnexæ are diseased; but whenever it is possible it is better to take away the uterus in addition to the adnexæ when the latter must be removed.

G.

Prognosis After Operation for Carcinoma of the Vulva.—Grünbaum (*Deutsche Med. Woch.*, 1906, No. 7) reports on the various operations performed during the last eight years, for this disease in Landau's Klinik, Berlin, and comes to the following conclusions:—A lasting freedom from recurrence is to be expected in several cases after radical operation, even though metastases have already appeared in the inguinal glands. In order to obtain the best possible results the incision in every case must be made well outside the disease, and the inguinal glands, together with the fatty tissue surrounding them, must be removed from

both sides, whether any alteration is to be felt in them through palpation or not. G.

The Tarnier Maternity Hospital.—The statistics of this hospital for the year 1905 are recorded by Perret (*L'Obstetrique*, 1906, No. 2-4). There were 1,679 patients treated; 26 of these gave birth to twins, and 86 were treated for abortion. The presentation was vertex 1,540 times, face 5 times, pelvic 59 times, and transverse 15 times. In 85 cases there was narrowing of the pelvis, 54 times the conjugata vera being 10.5 cm., 15 times from 10.5 to 9 cm., 16 times 9 cm., or less. Hæmorrhages during pregnancy or parturition occurred in 10 cases. There were 5 cases of placenta prævia, and one of eclampsia. The placenta had to be removed manually 35 times. There were 77 cases of atonic postpartum hæmorrhage. Prolapse of the cord occurred 16 times, and prolapse of the arm twice. The forceps were employed 77 times, version 33 times, curettage 70 times, accouchement forcé 3 times, perforation 3 times, Cæsarian section 4 times, suturing of the perinæum 28 times. The complete morbidity was 16.2 per cent., when due to uterine infection 3.8 per cent. The complete mortality was 0.6 per cent., that due to uterine infection being 0.23 per cent. Five women died from septicæmia, one each from peritonitis, double-sided pyelo-nephritis, uterine rupture and tuberculosis, 2 from hæmorrhage. As regards the children, 31 died during labour, 30 during the first 24 hours, and 5 in the following 24 hours. Five were mascerated when born. Of those which remained alive 150 were very weakly. The infantile mortality was 3.3 per cent.; 22 died from bronchopneumonia, 7 from septicæmia, 5 from erysipelas, 4 from asphyxia, 3 from congenital debility, 2 from malformation, and one each from syphilis and convulsions. The infantile morbidity was 16.8 per cent. Seven infants weighed less than 1,500g., 5 of these died; 32 weighed 1,500-2,000g., 8 of these died; 111 weighed 2,000-2,500g., 11 of these died. The mortality among these weakly infants was 16 per cent., the causes of death being congenital debility 11 times, syphilis 3 times, bronchopneumonia 8 times, and one each septicæmia and erysipelas. G.

Internal Podalic Version for Shoulder Presentation.—Concerning this question, Demelin *L'Obstetrique*, 1906, No. 2-4) writes that when the shoulder presentation is diagnosed during parturition, while the membranes are still intact, every precaution must be taken to prevent rupture of the membranes. One may try external version very carefully, but vaginal examination and any method of artificially dilating the cervix must be avoided as much as possible. In no case is Braxton Hicks' version to be performed. The woman is to be put to bed, and the more or less complete dilatation of the cervix is to be waited for, in order that internal podalic version may be chosen. When the membranes are ruptured, and there is no contra-indication to version, it is to be performed when the cervix is fully dilated, or at least sufficiently dilatable. If, on the other hand, the cervix is not yet sufficiently dilated, it must be dilated gradually with the hand till the latter slips gently into the uterus and the version can be performed. In such a case immediate extraction of the child is never to be adopted. The full dilatation of the cervix is to be waited for, and the expulsion of the child left to nature. When one is careful not to pull on the child too soon, there will be no danger that the cervix, no yet fully dilated, will surround the neck of the child and keep the head from being born. G.

Veronal in the Vomiting of Pregnancy.—Rowlands (Lichfield) (*Brit. Med. Journal*, November 24th, 1906). A healthy primipara, æt. 29, pregnant two months, developed serious vomiting; nothing was retained by the stomach, and sleep was rendered almost impossible by the retching. All food was stopped by the mouth on finding that iced champagne, effervescing saline mixtures and other remedies proved useless, and rectal feeding adopted. As the pulse became rapid and weak strychnine was given hypodermically. Pot. brom., xxx grs., was given in one of the nutrient injections, and repeated in two hours, but without any effect, and morphia, ¼ gr., also failed to produce a change. At the end of three days veronal, xxxii gr., in powder, was administered in a nutrient enema. The patient fell asleep within half an hour, and continued to sleep for eleven and a half hours, and at intervals for the next six, rousing up during the administration of nutrient enemata. There was no return of the vomiting for twenty-five hours, and when it recurred it was markedly diminished in severity. During the following ten days Brand's essence, kreochyle lime water, and barley water in small quantities were given, and retained occasionally for a few hours. At the end of that time sleep was only obtained in snatches of from one to one and a half hours, and as the patient was not getting on, another dose of veronal in the same quantity was given by the rectum, which induced sleep for ten and a half hours. A purpuric rash was noticed on the arms, which, however, passed off in twenty-four hours. The vomiting recurred at intervals, but gradually the patient was able to take more varied nourishment by the mouth, in addition to the nutrient injections, which were continued for some time. Sleep was obtained naturally in gradually increasing periods daily, and in one month from the commencement of the illness the patient was convalescent. Quickening took place normally, the patient remaining well. It is pointed out that the case is of interest both from the gravity it assumed and the beneficial results obtained from large doses of veronal per rectum at a time when induction of abortion was seriously under consideration. H.

Painless Labour.—Scott-Dickson (Dundee) (*Brit. Med. Journal*, December 1st, 1906) describes a case of this nature. The patient, a five-para, æt. 38, none of whose previous pregnancies had reached full term, ranging from the fourth to the eighth month, stated that the membranes had ruptured, and she therefore concluded that labour had commenced. A vaginal examination revealed the fact that the os was about the size of a five shilling piece, and that the head was fixed. The patient walked quietly about the room for about an hour and a half, but stated that at intervals of about fifteen minutes she had a desire to defœcate. During one of these periods a hand on the abdomen showed the uterus to be contracting. Another vaginal examination proved the os to be fully dilated, and the head descending. The patient was then kept in bed, and an hour later the child, a full-term average-sized female, was born alive. Just as the head passed through the vulva a slight pain of a "cutting" character was noticed. Quarter of an hour later the placenta was expelled painlessly, followed by a large gush of blood, but the uterus contracted well. H.

Epithelioma of the Clitoris.—Leigh Day (Colchester) (*Brit. Med. Journal*, December 8th, 1906) records a case of the above. The patient complained of irritation of the vulva, and scalding after micturition, with pain in the genitals. She further stated that there was a lump present. There was no hæmorrhage nor discharge. Upon making an examination a scarlet mass was discovered springing from the prepuce of the clitoris, and very tender to the touch. An operation for its removal was performed, and the mass proved to be a squamous-celled epithelioma of the clitoris. Until four months previous to the patient's seeking advice, nothing had been noticed. She was then troubled with pruritus. The mass was not noticed until two months before operation, which pointed to rapid growth. The patient's age was 60; she had borne eleven children, and the menopause occurred at 41. H.

It is reported that a London medical man, Dr. Albert Shaefer, is lying in a Paris hospital as the result of a murderous assault in the streets, apparently from motives of robbery.

NOTICES TO CORRESPONDENTS, &c.

☛ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to 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.

SUBSCRIPTIONS.

SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance.

CANADIAN.—Alas! there is no sort of way of getting at the person named. There is no specific designation in the title "Nurse," which is open freely to everyone who likes to assume it. It carries no guarantee of any kind, and is purely complimentary. If the woman named pretended to have a proper hospital certificate of three years training, and was engaged on that understanding, it might be possible to prosecute her for obtaining money under false pretences. A solicitor would advise you as to this, but we should not be very sanguine as to the result. When you have had a little experience of the British law you will find it is very lenient to a certain class of offenders.

M.R.C.P. (Brighton).—The advice of the medical man in attendance is likely to be sound as regards the question of operation. In any event, laparotomy is likely to be attended with no untoward results. It is hardly needful to add that any opinion as to the merits of the individual case, without a personal examination of the patient, must be extremely tentative and guarded.

SUCH IS FAME!

A CORRESPONDENT sends us the following account of an incident which happened to himself. Lecturing to a London County Council First Aid Class of shop assistants and servants recently, he came to deal in due course with the treatment of wounds and the use of antiseptics. Wondering how far the fame of Lister had filtered through to the lower middle classes, he inquired who it was who first discovered the value of antiseptics. There was a general puckering of brows for a few moments, then one better informed than the rest smilingly asked permission to speak. "Yes," said the lecturer, "who was it?" "Sanitas," replied the maiden.

SACCHARINE.—You will find a good deal of information on the subject of diabetes following fracture of the skull in a paper in Vol. LVII. of Guy's Hospital Reports.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, DECEMBER 19th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. J. Cantlie: Clinique (Surgical).

THURSDAY, DECEMBER 20th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m.: Mr. Hutchinson: Clinique (Surgical).

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m.: Chesterfield Lecture:—Dr. M. Dockrell: Bullous and Vesicular Eruptions; I., Urticaria; II., Pemphigus; III., Pompholyx; IV., Varicella.

FRIDAY, DECEMBER 21st.

LONDON SCHOOL OF CLINICAL MEDICINE (Dreadnought Hospital, Greenwich).—2.30 p.m.: Operations. 2.30 p.m.: Dr. R. Bradford: Medicine. 3.15 p.m.: Mr. McGavin: Surgery. Out-patient Demonstrations:—10 a.m.: Surgical and Medical. 12 noon: Skin.

SATURDAY, DECEMBER 22nd.

LONDON SCHOOL OF CLINICAL MEDICINE (Dreadnough Hospital, Greenwich).—2.30 p.m.: Operations. Out-patient Demonstrations:—10 a.m.: Surgical and Medical. 11 a.m.: Eye.

Vacancies.

County of London.—Horton Asylum, Epsom, Surrey.—Epileptic Colony, Ewell, Surrey.—Medical Superintendent of Horton Asylum, Epsom, Surrey. Salary £1,000 a year, with an unfurnished house. Applications to H. F. Keene, Clerk of the Asylums' Committee, London Asylums' Committee Office, 6 Waterloo Place, S.W.

County of London. — Horton Asylum, Epsom, Surrey. — Epileptic Colony, Ewell, Surrey,—Medical Superintendent of the Epileptic Colony, Ewell, Surrey. Salary £600 a year, with an unfurnished house. Applications to H. F. Keene, Clerk to the Asylums' Committee, London Asylums' Committee Office, 6 Waterloo Place, S.W.

Newport Borough Asylum, Caerleon, Mon.—Assistant Medical Officer. Salary £150 per annum, with board, apartments, and attendance. Applications to the Medical Superintendent.

Royal Mineral Water Hospital, Bath.—Resident Medical Officer. Salary £100 per annum, with lodging, board, and laundry. Applications to the Secretary.

Loughborough and District General Hospital and Dispensary.—Resident House Surgeon. Salary £100 a year, with furnished rooms, attendance, board, and washing. Applications to Thos. J. Webb, Secretary.

Manchester Royal Infirmary.—Director of the Clinical Laboratory. Salary £100 per annum. Application to Walter G. Carnt, General Superintendent and Secretary, Manchester Royal Infirmary.

Norfolk County Asylum, Thorpe, Norwich.—Junior Assistant Medical Officer. Salary £150 per annum, all found. Application to the Medical Superintendent.

Great Northern Central Hospital, Holloway Road, N.—Casualty Officer. Salary £100 per annum. Applications to L. H. Glenton-Kerr, Secretary.

Eastern Dispensary, Leman Street, Whitechapel, E.—Resident Medical Officer. Salary £120 per annum, with furnished residence, coals, and attendance. Applications to George W. Lisley, Secretary, 66 Great Prescot Street, E.

West Riding County Council.—Scalebor Park (Private Asylum) Burley-in-Wharfedale.—Assistant Medical Officer. Salary £150 per annum, with board, furnished apartments, attendance, &c. Applications to the Physician Superintendent.

Appointments.

BENNETT, H. G., M.R.C.S., L.R.C.P.Lond., House Physician to Out-patients at St. Thomas's Hospital.

BUTLER, G. G., M.R.C.S., L.R.C.P.Lond., to the Ear Department at St. Thomas's Hospital.

CASSIDY, M. A., M.B., B.C.Cantab., Resident House Physician at St. Thomas's Hospital.

COX, R. J. H., M.B., B.S.Lond., Resident House Surgeon at St. Thomas's Hospital.

DICKSON, A. N., M.R.C.S., L.R.C.P.Lond., Resident House Physician at St. Thomas's Hospital.

DIXON, WILLIAM JOHN, M.B., B.S.Madras, L.R.C.P.Lond., M.R.C.S., Medical Officer for the Templecombe District, by the Wincanton (Somerset) Board of Guardians.

DREW, J. H., M.B., B.S.Lond., Junior Casualty Officer at St. Thomas's Hospital.

DUNKLEY, E. V., M.B., B.S.Lond., House Physician to Out-patients at St. Thomas's Hospital.

EYRE, C. R. B., M.R.C.S., L.R.C.P.Lond., Senior Obstetric House Physician at St. Thomas's Hospital.

FRANKLIN, C. L., M.B., Ch.B.Vict., Junior House Surgeon at the Oldham Infirmary.

GAMLEN, R. L., M.R.C.S., L.R.C.P.Lond., House Surgeon to Out-patients at St. Thomas's Hospital.

GOTELEE, H. E., M.R.C.S., L.R.C.P.Lond., Senior Ophthalmic House Surgeon at St. Thomas's Hospital.

HEWETT, F. S., M.R.C.S., L.R.C.P.Lond., Resident House Surgeon at St. Thomas's Hospital.

HOOKER, A. W., M.B., B.S.Lond., Senior Casualty Officer at St. Thomas's Hospital.

HOWARTH, W. G., M.B., B.C.Cantab., Resident House Surgeon at St. Thomas's Hospital.

HOWITT, A. B., M.B., B.C.Cantab., Resident House Surgeon at St. Thomas's Hospital.

HUGGINS, G. M., M.R.C.S., L.R.C.P.Lond., to the Skin Department at St. Thomas's Hospital.

JUBB, ARCHIBALD, M.D.Glasg., Extra Assistant Physician to the Glasgow Royal Infirmary.

MACDONALD, S. G., M.B., B.C.Cantab., House Surgeon to Out-patients at St. Thomas's Hospital.

NIGHTINGALE, H. J., M.R.C.S., L.R.C.P.Lond., to the Children's Surgical Department at St. Thomas's Hospital.

PAGE, C. M., M.B., B.S.Lond., House Surgeon to Out-patients at St. Thomas's Hospital.

PHILPOT, H. A., M.R.C.S., L.R.C.P., House Physician to Out-patients at St. Thomas's Hospital.

READ, H. W., M.R.C.S., L.R.C.P.Lond., to the Dental Department at St. Thomas's Hospital.

SANKEY, W. O., M.B., B.S.Lond., Resident House Physician at St. Thomas's Hospital.

SQUIRES, H. C., M.B., B.Ch.Oxon., Resident House Physician at St. Thomas's Hospital.

SUHR, A. C. H., M.R.C.S., L.R.C.P.Lond., Junior Obstetric House Physician at St. Thomas's Hospital.

TREVES, F. B., M.R.C.S., L.R.C.P.Lond., to the Throat Department at St. Thomas's Hospital.

WALKER, S. L., M.R.C.S., L.R.C.P.Lond., to the Skin Department at St. Thomas's Hospital.

WALLACE, J., M.R.C.S., L.R.C.P.Lond., to the Throat Department at St. Thomas's Hospital.

WARD, W. C. A., M.R.C.S., L.R.C.P.Lond., Junior Opthalmic House Surgeon at St. Thomas's Hospital.

WHITEHEAD, C. E., M.R.C.S., L.R.C.P.Lond., House Physician to Out-patients at St. Thomas's Hospital.

WHITEHOUSE, H. B., M.B., B.S.Lond., House Surgeon to Out-patients at St. Thomas's Hospital.

Births.

KELLY.—On Dec. 14th, at 26 Blythswood Square, Glasgow, the wife of A. Brown Kelly, M.D., of a son.

LLOYD.—On Dec. 14th, at 6 Victoria Place, Haverfordwest, the wife of Perceval A. Lloyd, F.R.C.S.Eng., of a daughter.

Marriages.

DODGSON—GOOD.—On Dec. 8th, at Lyndhurst Road Church, Hampstead, W. Dodgson, M.D., of Southwaite, Carlisle, eldest surviving son of the late Dr. Dodgson and Mrs. Dodgson, Derwent House, Cockermouth, to Annie Florence, second daughter of Henry Good, Esq., of Alvaston, Arkwright Road, Hampstead.

GROUND—MACBETH.—On Nov. 14th, at St. Mary's, Johannesburg, Arthur Edward, eldest son of Edward Ground, B.A., M.D.Cantab., Maidstone, to Marjorie, youngest daughter of the late Major John Macbeth, 42nd Highlanders (Black Watch).

LAMBERT—ANDERSON On Dec. 14th, at the Cathedral, Singapore, Stephen George, youngest son of the late Richard Lambert, of Putney, and formerly of Roehampton, to Ethelwyn, only daughter of the late William Anderson, F.R.C.S., of London and Walton-on-the-Hill.

Death.

SYKES.—On Dec. 16th, at Westfields, East Grinstead, Walter John Sykes, M.D., F.I.C., in his 65th year.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXIII. WEDNESDAY, DECEMBER 26, 1906. No. 26

NOTES AND COMMENTS.

Wanted—A Big Man.

The amount of annoyance and delay caused to medical men by being obliged to kick their heels about police-courts while trumpery cases are being disposed of, is exasperating in the extreme. Would that all magistrates were like Mr. Fordham. At the North London Police Court the other day when a medical man entered the witness-box, Mr. Fordham said he had noticed him in court all the morning, but did not know he was a doctor. He had a very strong opinion about keeping medical men from their practices longer than was absolutely necessary, and he had given strict orders that no doctor should be summoned till 11.30 a.m. at the earliest. He then inquired who was responsible, and was told a sub-divisional inspector, to which he replied that he wanted a bigger man than that to see his orders carried out. He then went through all the big men in the police service, and finally decided on the biggest, namely, the Chief Commissioner, and to him he wrote saying that he ought to issue an order that doctors were to be inconvenienced as little as possible in giving police-court evidence. This is a real grievance that Mr. Fordham has put his finger on, and he deserves the thanks of the profession for so manfully taking up the cudgels on their behalf.

London Meat Inspection.

A SPECIAL report on meat inspection in the City of London has been presented by Dr. Collingridge to the Sanitary Committee of the Common Council, in which he admits that under prevailing conditions it is useless to try to discover disease in the carcases at the Central Markets; all that can be attempted is to find out and seize unsound and decomposed meat. As there are no public abattoirs, it is impossible at present to inspect the organs of animals slaughtered, and so evidence of disease is rarely obtainable. But even as things are, Dr. Collingridge's staff is too small to cope with the work it has to do, for there are only five inspectors to look after the 1,352 tons of meat daily sent to the Central markets—a ridiculously disproportionate number. Moreover, it seems that the more carefully inspection is carried out, the more bad meat is discovered, for nowadays three times as much bad meat is found as in 1891. Altogether things seem to stand in need of considerable reformation in the City, and as an enormous proportion of the food supply of the country passes through its confines, it is a matter for some anxiety that greater care cannot be exercised by the responsible authorities.

Mrs. Osler, æt. 100.

There is a little irony, albeit of a pleasant order, in the fact that Mrs. Osler, the mother of the Regius Professor of Medicine at Oxford, should just have celebrated her hundredth birthday. To the man in the street her distinguished son is principally known as an ogre who would "euthanase" all people at sixty, and the fact that his own mother should have achieved the patriarchal age she has just attained is not without a humorous aspect. There was a great gathering at Toronto to honour the occasion, Professor Osler, various other children, grandchildren, great-grandchildren, and a host of friends. Naturally a reason had to be assigned for the phenomenal longevity of the heroine, and the Regius Professor attributed it to the fact that she is "always joking." Care and worry it is that kill, not hard work, and not sustained exertion. "Laugh and grow fat" may be good philosophy, but laugh and live long is better. If we could all enjoy Mrs. Osler's even temperament and happy disposition, we might drink and smoke, and keep late hours with comparative impunity.

Death of a Cancer Cure.

The public activity of the Liverpool herbalists has been several times commented on in our columns. These scientific gentlemen, it may be remembered, are anxious to establish a herbalistic medical school and to undertake "research" into cancer. There is a charming naïveté about a letter which one of them has lately addressed to a Northern contemporary. It begins: "Sir,—You will no doubt be surprised to hear that Mrs. Cottam, the lady reported to have been cured of cancer, passed away on Monday at noon. I regret to have to communicate this news to you, but feel it my duty so to do, in view of the interest you took in the case and in the subsequent investigation. . . . A botanic practitioner who saw her on Sunday, when she had a serious relapse, diagnosed it as mercurial re-action, the result of continued taking of drugs. . . . I feel sure that if the case could have been taken in hand earlier, and without previous years of ill-health, and the continued taking of medicine and the operation, a different result would have occurred." We do not wish to make capital out of the death of a fellow-creature, but the facts speak sufficiently loudly for themselves.

LEADING ARTICLES.

A BONESETTER'S CHALLENGE.

THE practice of unqualified people in medical and surgical fields—alias quackery—is permitted by the State. There is accordingly nothing to prevent them gulling the public with catchpenny pretentions. This attitude on the part of the legislature is absolutely illogical. They say that the duly qualified medical practitioner must have previously undergone a long and arduous course of special training and have passed stringent examination tests as to the soundness of his knowledge. The declared aim of the Medical Acts relating to medical practice is to enable the public to distinguish qualified medical men. That definition of purpose connotes that the public should be protected against the harmful practices of those who, being medically unqualified, nevertheless pretend to special knowledge in medical matters. The consequence is that any ignorant person is able to set up as a cancer-curer, a nerve specialist, a "bone-setter," or what not, and to work an infinite amount of harm to His Majesty's lieges, while, as a rule, he fills his own pockets with sums that to the average qualified practitioner would exceed the dreams of avarice. Of all the crew of impudent pretenders to special knowledge the bone-setter strikes us as being *facile princeps*. A typical sample of his preposterous claims may be found in a notorious irregular practitioner named H. A. Barker. That gentleman, conscious, no doubt, of the value of advertisement, is given to issuing challenges to the medical profession to investigate his methods. Of course we are aware that in noticing his latest effusion we are playing into his hands, so far as the granting of a huge free advertisement is concerned. However, our opinion of Mr. Barker and his methods will be so freely expressed that he is welcome to any slight advantage that he may derive from the fact that his name has been mentioned in one of the medical journals for which he expresses so much contempt. The circular advertisement to which we refer is a diffusely-written pamphlet written in the form of "an open letter" to the President of the Royal College of Surgeons of London. There is a Napoleonic air about this document that is characteristic of Mr. Barker. His tactics are those of the resolute guerilla chieftain who not only invades the rich city, but attacks the Governor's residence. Not only does he declare war to the knife against the medical profession, but he challenges the titular head of surgery in the United Kingdom to mortal combat. The expression, "war to the knife" is perhaps hardly suitable in connection with this gentleman, for he claims the proud title of "bloodless" surgeon, and appears to have assumed the American name of "osteopath," which was lately covered with world-wide ridicule by Mark Twain. The letter begins with a handsome admission that it is the duty of the general Medical Council to guard the public "to the best of its ability from the intrusion of quackery and pretence"—a duty, by the way, that the Council refuses to recognise. At the same time, he claims it is their duty to examine into any well-certified means for the removal of suffering. In other words, the Council is to be called upon to examine all irregular plans of medical treatment—including Mr. Barker's—and if found to be of any service, to grant a kind of informal official recognition of the claims of each particular method so approved. Conversely, we presume, if found wanting the Council's condemnation would put an end to any particular method found wanting. He next makes much of the fact that the discovery of the circulation of the blood, and of various other scientific truths, was at first rejected by the medical profession. At the same time we can safely assert that sooner or later every great truth has found acceptance, and every great error has been rejected by medical men. Nothing has ever ultimately proved right, for example, that has been before the medical profession for so many years as "bone-setting." Medical science is ever on the look out for help from any quarter whatever, and is ready to test anything. The Rōntgen rays, for instance, came from non-medical sources, so did the germ theory of diseases. An analysis of Mr. Barker's claims to superior knowledge reveals the assumption of something in his methods and manipulations that he does not specify. That is a kind of cheap challenge that is easy to make and difficult to accept. He asserts in one place that he is able to replace knee-cartilages displaced at football, so that the player is able to return to the football field in a day or two or a week or two, as the case may be, "as efficient as ever." That is so unlike any ordinary surgical experience that we should refuse to accept it except upon actual demonstration of a sufficient number of cases accurately noted as to anatomical and clinical dates and results. The general tone of assertions that are advanced in place of argument and proof may be gathered from the following passage:—"On an overwhelming average the osteopath cures and 'the competent surgeon' fails to cure. His artificial aids and artificial muscles are ineffective where the application of an intelligent persuasive leverage brings the patient to his normal state." That is to say, Mr. Barker claims powers that have been denied to the long line of illustrious surgeons that have gradually advanced British surgery to its present pitch of perfection. Recently the advent of the Rōntgen rays has enabled the surgeon to make a far more exact diagnosis in many deep-seated injuries and diseases of bones and joints. It is, of course, open to the bone-setter to produce radiographic evidence as to the truth or otherwise of his assertions as to displacements and injuries of bone. Mr. Barker declares he wants no advertisement as he makes an income, and enjoys the confidence of his patients. A more scathing commentary on the worthlessness of the Medical Acts in the protection of the public against the wiles of quackery than this "open letter" it would be difficult to imagine.

A MIDWIVES BILL FOR IRELAND.

There is little doubt that at the present moment the subject of the restriction of the practice of unqualified midwives in Ireland and of the registration of duly qualified women is receiving considerable attention, and it is by no means improbable that the near future will see the production of a Government measure for effecting these objects. The necessity for some action of the kind has been made very evident, not only in order to improve the class of midwife attendant upon the poor in Ireland, but also to remove the present injustice to Irish trained nurses which has resulted from their non-inclusion in the English measure. Two courses are open to the Government: either a short Act can be passed extending the present Midwives' Act to Ireland, or a new Act can be passed for Ireland alone. To the former of these courses there are many and obvious objections, many of which will be patent to the readers of this journal. They may be briefly summed up by saying that the present Central Midwives Board has not shown itself suitable for the management of the business entrusted to it, and that there is no reason to think it would be more successful in managing additional business. Moreover, it has shown itself as a whole singularly ignorant of the qualifications of Irish nurses, and intolerant towards even the most celebrated Irish training institutions. We think that there would be few in Ireland who would consent to a proposal to place Irish midwives under the Board. It follows, then, that a fresh Act is necessary, and it may not be unprofitable to consider some pitfalls which must be avoided. The English Act has failed because in the first place it has constituted a Board in so loose a manner that its personnel is unbusinesslike, and because so many conflicting interests are represented that the vital questions at stake have often been lost sight of in undignified squabbles. We have no hesitation in saying that an Irish Board, if it is to command confidence and to work with success, must be constituted on entirely different lines, and must contain a majority of medical men. The conception that a Board of this kind can be satisfactorily worked if it is under the control of a lay majority has been proved to be fallacious. None but medical men can attach the necessary relative importance to details of training and to the different points in the control of midwives, and, though it is right that the Board should also contain lay members, it is essential that its majority should be members of the medical profession. Next to the constitution of the Board, great difficulty is sure to arise in framing the financial clauses. The English Act provides that under certain specified circumstances a midwife must summon medical aid, but it does not provide any means by which the medical man so summoned may be paid, in the case of indigent persons. This difficulty in Ireland will not lead to so much trouble as in England, because there in such cases the midwife is always entitled to summon the Dispensary Medical Officer. There are, however, other cases in which the patient may not be entitled to the attendance of the Dispensary Medical Officer, but in which her friends may be unwilling to pay for medical advice. In such cases, seeing that it is compulsory on the midwife to send for the medical man, and that though there is no legal compulsion there is strong moral compulsion on the latter to answer her summons, some provision should be made for his payment. Lastly, there is the necessity of avoiding so far as possible the creation of a class of inferior and untrained medical practitioner. This is a difficulty which is hard to overcome, and which will be successfully combated by the creation of a suitable Central Board rather than by clauses in the Act itself. In conclusion, we venture to express the hope that any wise action of the Government in this matter will meet with the support of the whole body of the profession in Ireland. There is no doubt that legislation is necessary in the interests of the sick poor, and though such legislation may inflict a slight amount of injury on the medical profession, the public spirit which has always actuated our body should lead us to support a necessary reform. In return, the least that can be asked of the creators of the Bill is that they will avoid amateurism, that in the drafting of the Bill they will be guided by the advice of those who are best able to give advice, and that the working of the Act will be entrusted to those who alone are competent to work it with success.

NOTES ON CURRENT TOPICS.

Saucepan and Appendix.

If it be unfashionable for people not to have had appendicitis, it is as least as unfashionable for medical men not to have a theory as to the causation of the malady. One medical man thinks it is due to frozen meat, another to red rubber corks in ginger-beer bottles, a third to the use of enamelled saucepans. The last view, which is new to us, was recently enunciated by Sir James Sawyer, before the Birmingham Medical Society, it appears, and we can only admire the courage of the physician who can take up such a position in the heart and centre of the iron manufacturing trade. Already the storm has burst, and *The Ironmonger* has been emptying the vials of its sarcasm on the devoted head of the originator of the theory. We cannot undertake to say that its reasoning is faulty if it at all correctly represents Sir James Sawyer's argument. The writer puts it thus: Appendicitis and the use of enamelled crockeryware came into vogue at the same time; the enamel is apt to become cracked and spicules are dislodged; such particles when introduced into the intestine are apt to set up inflammation. Therefore, appendicitis is caused by enamelled cooking ware. The only flaw in the argument is that none of these spicules have been demonstrated in the lesions. On the

same principle *The Ironmonger* is prepared to show that meat-choppers cause appendicitis. Apart from chaff, the theory that enamelled cooking vessels are the originators of appendicitis has a good deal to be said for it *primâ facie*, and it is well worth bearing in mind. The remarkable increase of appendicitis of recent years must be due to some active cause.

The Passing of Dowie.

THERE is always something pathetic in the break-up of a strong man, but in the case of the prophet Dowie the pathos ends there. There seems to be no doubt that he is now totally insane, and so enfeebled in health that his life cannot be much prolonged. His wife and son are said to have deserted him, his followers have seceded, and his debts amount to about a million pounds. The last scene of all this strange, eventful history is therefore less than simple nothingness, for the prophet is discredited and spurned. The stupendous fact remains that this extraordinary and erratic genius has been able to bamboozle hundreds of more or less educated people for thirteen years, to extract money from them for his schemes, and to make them his dupes spiritually and physically. The depth of credulity in human nature thus revealed is one that must never be lost sight of in taking any scheme into account; it may, indeed, safely be said that there are plenty of people in the world who will believe anything that is said to them. Already on the ruins of the Dowie edifice a successor is trying to raise up a little kingdom of his own. The new impostor is named Voliva, and he himself is suspected of mental weakness. But no doubt he will get adherents. It is not stated if he has taken up the curing business, but that is always a safe card to play.

Liability for Typhoid Infection.

OF late years there has been a marked tendency in the direction of attaching legal responsibility to the owners of insanitary premises. Lately a striking case of the kind, the report of which appeared in our news columns last week, was settled in the King's Bench Division. An action for £1,250 damages was brought by a lady against a medical man, the proprietor of a hydropathic establishment in the Midlands, under the following painful circumstances. The plaintiff with her two sons, who were attending Eton, paid a visit to the institution in question, where they unfortunately contracted enteric fever, and one of the boys died in consequence. The case was settled on payment of the amount claimed, but the plaintiff clearly stated that she agreed to that course only now that attention had been drawn to the dangers run by the public. On the other side it was stated that the defendant denied that he was personally responsible, and said that point would have to be determined by subsequent litigation. Of all diseases enteric fever is emphatically preventable, and it is to be hoped that the ultimate blame will be fastened on the right shoulders. A hydropathic establishment is the place where one would naturally expect an absolutely pure supply of water.

The Income Tax and the Medical Profession.

THE Report of the Select Committee on the Income Tax will, on the whole, give satisfaction to the professional classes. It does not, of course, go far enough to satisfy the more extreme, but, nevertheless, if its recommendations be carried out it will do much to lessen the burden on professional shoulders. For the first time in our economic history the principle for which we have contended—differentiation between earned and unearned incomes—is admitted. While this distinction may present difficulties of application in detail, the general idea is clear enough. Apart from this differentiation, the proposals are in the main on the line of extension of the existing abatements on small incomes. Thus, it is proposed to allow abatement on incomes up to £1,000 a year, instead of £700, as at present, and to impose an extra tax on incomes exceeding £5,000 a year. The differentiation as to "earned" and "unearned" is only to apply to incomes not exceeding £3,000. We cannot, of course, hope for an immediate translation of these suggestions into law, but it is satisfactory to have it established on the authority of a Select Committee that the changes for which we have contended are practicable, and there is no reason why some of them, at least, should not find their way into the next Budget.

Fortunes from Quack Medicines.

A NOTICEABLE feature about the quack medicine business is that of the most glaring and most successful enterprises the proprietors are generally Americans or Colonials. Although it may be comforting to reflect that home quackery is of comparatively small proportions when looked at in the light of American quackery, it is not reassuring to find that any dealer in patent medicines from abroad or the Colonies can command the advertisement columns of the British press if he comes with his money in his hand. Such, unfortunately, is the case. No deal is too glaring for most newspapers. During the last few weeks the wills of several large patent medicine directors have been published, and they bear eloquent testimony to the profits derivable from the trade. Thus Senator G. T. Fulford, proprietor of "Dr. Williams' Pink Pills for Pale People," left a fortune amounting to no less than £1,311,000, derived chiefly from that concern; Mr. Charles E. Fulford, of the "Bile Beans" Company, a comparatively new affair, left £67,187; and his colleague, Mr. E. A Gilbert, £31,252. Mr. Lyman Brown, of New York managing director of A. J. White, Ltd., the firm which trade in "Mother Seigel's Syrup," died at the Hotel Cecil last October, and his will shows property in the United Kingdom alone of £31,782, as to how much he had in America we have no information. Medical men who toil day in and

day out among the poor may be inclined to look enviously on these sums, piled up by the methods used by their proprietors, but the consciousness of having tried to alleviate sickness and pain will amply compensate. There are more precious things than gold in the world. *Nudus intravi, nudus exeo.*

Anti-Vivisection Meetings.

The pugnacity of the Anti-Vivisection Societies shows itself characteristically in internecine conflicts between themselves; indeed it is a question of policy whether they would not be better left alone to fight out their differences, as the result would probably be the same as in the case of the Kilkenny cats. There was an amusing instance of the harmony prevailing among the members of the "cause" in the holding of two meetings of protest, within a day or two of each other, by the British Union and the National Anti-Vivisection. The former got in the first thrust, and with Mr. Lupton in the chair protested against the one-sided constitution of the Royal Commission on Vivisection, "now conducting its inquiry behind closed doors." Mr. Coleridge's organisation, however, soon got in their counter, this time against the refusal of the Royal Commission on Vivisection to hold its meetings in public or to allow the National Anti-Vivisection Society to be represented by counsel. Translated into ordinary language, these protests mean (*a*) that both societies are disappointed at not being able to perform in public; and (*b*) that each has been unable to put up its protagonist in the character he (the protagonist) would like. The former grievance has had any semblance of reality taken out of it by the resolve of the Commissioners to publish periodical reports of the evidence, but this is regarded as a very inadequate concession; sensationalism needs to be served up hot, or not at all. The second grievance, that Dr. Hadwen was not put on the Commission as an "expert anti-vivisectionist," is a "bit thin"; we have yet to learn in what way Dr. Hadwen is an expert. On the other hand, that Mr. Coleridge should be disappointed in not appearing as "counsel" before the Commission is a "bit thick," considering his known partiality for legal proceedings. For ourselves, we can imagine that the public gaiety has lost much in not having had Dr. Hadwen to overrule Mr. Coleridge, or Mr. Coleridge to object to Dr. Hadwen's objections to his questions.

A "Cure" for Opium Smoking.

The absurdity of so-called "drink cures" must be of course apparent to educated medical men. To find a specific antidote to alcoholic craving is to seek for the philosopher's stone or any other phantom. In most cases the "drink cure" simply substitutes one form of nerve poison for another, usually in the shape of some narcotic principle. Incidentally by thus trading on human weakness and credulity the vendors of the "cure" pile up riches unto themselves in the fashion one is wont to associate with quick-witted and unscrupulous business methods. At times they carry on their trade under a semi-philanthropic guise, but a little investigation soon reveals the trail of the serpent in the enterprise. With this experience of the Western world in mind it is with much doubt and suspicion that we read of a "new cure for the slaves of the opium habit in Malaya." The anti-opium movement in Malay has come to resemble a religious revival in England or America. An anti-opium society has introduced a "cure" for the opium habit in the shape of the dried leaves of a wild plant taken as an infusion. There is the usual testimony of reformed victims of the vicious habit, and the interesting fact that the price of the leaves is ten dollars per picul. Verily, the love of money is the root of all evil.

British Homeopathic Association.

The fifth annual meeting of the British Homeopathic Association took place on December 12th at Lord Cawdor's house, and the annual report of its work was read by the Secretary. In this great stress was laid on the opposition of homeopaths to "vivisection," although "research work of considerable value" had been completed at their new laboratory. The "research" work which homeopaths delight in is, we believe, confined to the "proving" of drugs, a delightful process which varies directly as the disposition and predispositions of the provee. Without dwelling, however, on the value of these searching scientific tests, we may remark that these provings are not mere experiments on animals, but experiments on man, and that if it is bad to give animals, say, a hypodermic injection of strychnine and then under an anæsthetic take a blood-pressure tracing, it must be infinitely worse to give a man a thousandth of a minim of tincture of belladonna and see if he survives. For it must be remembered that the more a drug is divided the more potent, in Hahnemann's opinion does it become. It is entertaining to read, however, that the present-day use of serums, vaccines, and emulsions brings the rest of the profession nearer to homeopathy, though we will not, of course, "acknowledge" it, but in the crude form in which we know these preparations we are "likely to do more harm than good." We remember some time ago a homeopath claiming diphtheria antitoxin for their own, but we fail to see how that or any other serum or vaccine is to be obtained without "vivisection."

Claim for Fees.

If medical men are liable for damages for mistaken treatment, it seems to be only fair that patients should be similarly liable if they do not carry out proper treatment when prescribed, for their failure to get well is liable to discredit their medical attendant. This month in the Kidderminster County Court a practitioner, Dr. B. Addenbrooke, brought an action for six guineas against a patient. The latter had damaged a

finger, and Dr. Addenbrooke having found a tendon severed, skilfully re-united it, and told the patient to attend at his house immediately if the finger were painful. There was great pain in the finger subsequently, but the patient did not put in an appearance for four days, and the operation eventually turned out unsatisfactorily. He then refused to pay. The judge said that there had been no want of skill on the plaintiff's part, and that the unhappy result was due to the patient's neglect. He therefore, gave judgment for the full amount. The "no-cure no-pay" system has no place in medical contracts, and we are glad to see the fact so satisfactorily confirmed.

Antitoxic Cruelty to Animals.

LIKE many progressive journals, the *Tribune* is given to dalliance with the unorthodox in medicine. A delightful letter appeared recently in its columns over the signature "M.D.," who takes his text from Dr. Hadwen's recently-issued pamphlet—we had almost written "tirade"—on "The Antitoxic Treatment of Diphtheria." He begins by discussing, with temperate reasonableness, the statistics of the disease before and after the introduction of the preparation in question. He then scores his one point, namely, that the fall in the total mortality began practically in 1900, whereas it should have shown itself immediately upon the introduction of antitoxin in 1895 or 1896. There are obviously fallacies in the way of accepting his conclusion. Much more, for instance, has been learned about the preparation, the dose and the prophylactic and curative properties of antitoxin. Moreover, its use had not become by any means general in 1896, and the ordinary causes of the increase in the diphtheria wave were still at work. But when "M.D." comes to state his own views we find the Tartar strain disclosed with a vengeance. Antitoxin treatment, he says, is a passing fashion destined to be crushed out of existence in a few years. The system, he vows, is associated with "too much cruelty to animals," and, moreover, is a filthy system of treatment. In short, it would be hard to pack a short letter with more errors of apprehension and reasoning than that of "M.D." After all said and done, he admits the fall in 1900, and so gives his case away. As to the cruelty to "animals," does he mean to mankind (*i.e.*, by way of hypodermic injection) or to the lower animals—for man is an animal no less than a horse? Then as to serum treatment, why is it more "filthy" and cruel to extract the serum of the horse and inject it into the human circulation than it would be to kill a calf or a pig (often under circumstances of revolting pain and cruelty),and thereupon introduce a lower animal serum into the human economy by the more roundabout agency of the slaughter-house and the kitchen? Assuming him to be really a Doctor of Medicine, "M.D." belongs to the type of intellectually untrained practitioners who constitute the scanty handful of medical anti-vivisectionists.

A Police View of the Infectivity of Consumption.

Of all the vexed questions that abound in public health that of the proper attitude with regard to the infectivity of tuberculosis is one of the most thorny. Is the malady to be scheduled among the infectious diseases, and thus brought within the machinery of notification, isolation and disinfection applied thereto? Or is it to be regarded in its present stage as a problem to be decided locally? At any rate, the fact remains that Government does not recognise that tuberculosis as such should be scheduled amongst the infectious diseases. That being so, it is not a little surprising to learn from a letter addressed to the editor of the *Manchester Courier*, and published on December 8th, that the writer, wishing to remove his mother who was suffering from advanced phthisis, to a sanatorium, was refused the police ambulance on the ground that tuberculosis was infectious. The applicant was then refused the use of an ambulance used for removing patients to the infectious hospitals, though why this was done it passes the mind of man to conjecture. The unfortunate man, who was thus bandied about between pillar and post, says that a high official advised him to use a cab. If that be the method of Manchester the sooner the ambulance system of the town is reorganised the better for all concerned. We imagine, however, the writer must have been labouring under a misapprehension with regard to the cab.

PERSONAL.

PERMISSION has been granted by the King for Dr. Kenneth Scott, F.R.C.S.Edin., to wear the Insignia of the Fourth Class of the Imperial Ottoman Order of the Osmanieh, lately conferred on him by the Khedive.

A NUMBER of distinguished Yorkshiremen, including Lord Halifax, Lord Allerton, Sir James Kitson, and Sir A. T. Lawson, are arranging to have the portraits of Professor Clifford Allbutt and Mr. Pridgin Teale painted by a well-known artist, in order to commemorate their great services to medical science in Leeds and the West Riding.

AN inquest was held at Brighton on December 17th on the body of Mr. Frederick Alfred Ficher, a retired medical man. Mr. Ficher met his death by falling from a third floor window. A verdict of "Accidental death" was returned.

AT the thirteenth annual dinner of the Royal Southern Hospital, Liverpool, earlier in the month, Dr. Macalister was in the chair. He was supported by Sir Alfred Jones, Mr. Rushton Parker, the Rector of Liverpool, and others.

AT a dinner in support of the Poplar Hospital for Accidents, held at the Holborn Restaurant on December 19th, Mr. Edward F. Turner took the chair. Sir John Hollams, Sir Edgar Speyer, Sir Henry White, the Hon. Sydney Holland, Mr. T. H. Openshaw, and other distinguished guests were present.

A Clinical Lecture

ON

THE DIFFERENTIAL DIAGNOSIS OF TYPHOID FEVER AND APPENDICITIS

By PROFESSOR F. LEJARS, M.D.,

Of the Faculty of Medicine of Paris.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

Some ten years ago one of my medical colleagues, a most careful observer, sent to me for operation a young woman who had been admitted to hospital two days previously. For three days she had been suffering from pain in the abdomen, more particularly in the right iliac fossa. She presented some swelling of the belly, and her temperature was 101.5° F. with nausea and prostration. My colleague suspected appendicitis, calling for immediate operation, and as I was of the same opinion, I performed laparotomy, only to find a small, perfectly normal appendix, which, all the same, I thought advisable to remove. The cæcum was distended and gurgly, and was red in places. The wound was closed, but the prostration, insomnia and diarrhœa continued, and she developed a well-marked typhoid fever, from which in due course she recovered.

I have never forgotten the lesson, and since then I have more than once found myself face to face with doubtful cases of the same kind in which we were called upon to make the differential diagnosis between typhoid fever and appendicitis. Here is another case in which this problem presented itself under circumstances that lend themselves to the discussion we have in hand. In this instance the balance of opinion was in favour of its being typhoid fever, the diagnosis being based on what appeared good and sufficient reasons, yet the examination of the blood and the subsequent course proved it to be a case of appendicitis. A youth, æt. 20, was seized suddenly on September 27th with abdominal pain and colic without any particular localisation. There was diarrhœa, anorexia, and general discomfort. Three days later the pain became more acute and there was vomiting. On October 1st the pain became still more severe, and now it was referred more particularly to the right iliac fossa. On the following day the patient was brought into my wards. He was extremely prostrated with stupor, and had a pale anxious facies. He passed from six to eight yellow stools in the twenty-four hours, the belly was distended, and tender all over, but more so in the right iliac fossa. Temperature 100.5° F., pulse 65, regular. No change occurred during the next day or two. Examination of the blood showed: red corpuscles 3,600,000, leucocytes 19,000. Sero-diagnosis was negative. Some resistance was felt over the right iliac fossa; the diarrhœa and insomnia persisted. Matters remained about the same until the 8th, though the diarrhœa subsided somewhat. The iliac pain was very pronounced, the temperature oscillated between 100.5° and 101° F. On the 10th the blood examination gave, 3,900,000 red and 28,000 white corpuscles, the pulse remained slow (64) and the general appearance was disquieting.

We were prepared to operate, but the absence of well-marked signs in the iliac fossa induced us to postpone the intervention, and the patient slowly recovered.

I shall discuss later on the assistance to be derived from the examination of the blood, but for the moment I wish to call attention to the extraordinary similarity between the symptoms of this abnormal appendicitis, and those of typhoid fever. Our view was that it was a case of acute enterocolitis with appendicitis, but for some days it was extremely difficult to form an opinion. Such cases are by no means rare, and they have on various occasions led to the abdomen being opened in typhoid fever, and on the other hand, we have been induced to withhold our intervention in cases of appendicitis until it was too late. This being so, such cases deserve our best attention.

It seems to happen more frequently that appendicitis is diagnosed when the patient is really suffering from typhoid fever than the converse. Nevertheless, in two instances we have diagnosed typhoid fever in patients sent to us for "appendicitis," and which turned out to be typhoid fever. But surgeons are not always equally fortunate. Kelly and Hurdon report several striking examples of this. A nurse, æt. 23, was seized with excruciating pain in the abdomen while on duty. The abdomen was found to be distended and resistant, there was nausea and then vomiting, and the temperature ran up to 106° F. They diagnosed acute perforating appendicitis, and operated, but it turned out to be typhoid, from which she died. In another case a boy, æt. 8, suffered for two days from pain in the right iliac fossa with distension and muscular rigidity, and a temperature of 104° F. He was operated on for appendicitis, but the appendix was healthy, and it again turned out to be typhoid, fortunately followed by recovery. A third case, with a less fortunate ending, was that of a medical man, who for two years had been suffering from attacks of colic thought to be appendicular; ultimately the pain in the right iliac fossa became so severe as to necessitate his taking to his bed. Matters went on thus for some weeks, when the pain became localised exclusively in the right iliac fossa, and was diagnosed to be due to appendicitis. The belly, however, was flat and soft. He was operated on, the appendix was found adherent to the cæcum, but in no wise diseased. Six days later internal hæmorrhage set in, rose-coloured spots were detected, and the spleen could be felt. He died on the twelfth day. It would be easy to multiply similar observations.

Although it is less common for an appendicitis to be mistaken for typhoid fever than the converse, the consequences of the error are even more to be feared should the error persist. Box and Wallace (*Lancet*, June 6th, 1903) record the case of a man,

æt. 50, who was suddenly seized with pain in the right iliac fossa; the temperature went up, the pulse was 120, with intermittent delirium at night and slight diarrhœa. During the third week there were three copious hæmorrhages with bright red blood, and typhoid fever was diagnosed, although no rose-coloured spots were seen and the sero-reaction was negative. Death occurred on the twenty-first day. *Post mortem* they found an abscess in the right iliac fossa around the appendix, but no trace of typhoid ulceration.

From what precedes, it will be seen that the conditions under which the mistakes were made were very dissimilar. There were acute cases, with sudden onset, high fever and rapid pulse, a bad general state from the beginning, abdominal distension, an ill-defined pain in the right iliac fossa, which might be either typhoid fever or appendicitis. Generally, however, the onset was more gradual, corresponding fairly well to the period of invasion of enteric fever. In these doubtful forms what led to the diagnosis of appendi itis was the prominence of the iliac pain and the partial subsidence of the other signs. The weight of opinion was in favour of typhoid when there was diarrhœa, headache, and stupor. In typical cases, of course, such an error could only arise in consequence of inadequate examination, but in the mixed cases under consideration certain signs are wanting, and those present can only be rightly interpreted by an attentive study in their totality, none of them viewed separately being pathognomonic.

In appendicitis the onset is usually more acute and severe. The pain sets in suddenly and forthwith increases in intensity. Nausea and vomiting usher in the scene, and the temperature goes up. Even in cases which, later, become obscure or in which unexpected accidents supervene, it is rare for this history not to be obtained. The pain may be moderate, it may not be just where we should expect to find it, it may be lower down, peri-umbilical, or sub-hepatic, but it is quite exceptional for it not soon to become localised in one spot, usually at or in the immediate neighbourhood of McBurney's point. It is not only sensitive to pressure, but the pain is there always. The wall is tense, rigid, and the least pressure accentuates the muscular resistance. We may get iliac tenderness at the onset of typhoid, and sometimes this tenderness assumes the character of genuine pain, but it is more diffuse, less fixed, it is specially marked on pressure, and when it is sought for the wall remains supple. Gurgling, of course, signifies little or nothing.

We know that diarrhœa is by no means rare in appendicitis, and that it is especially common in the very grave septic cases. It is consequently a grave element of prognosis. But diarrhœa from the onset usually indicates the crisis of entero-colitis, in the course of, or following which, the appendicitis has developed. It may be very copious during the first few days, and this is unusual in typhoid, in which the diarrhœa as a rule only sets in after a preliminary period of constipation. We meet with every variety, however, and no hard and fast rule can be laid down, but the significance of this inaugural diarrhœa must not be lost sight of.

The insomnia, headache and mental depression may of course be merely due to the fever, and we must not forget that these symptoms occasionally assume a very grave aspect, closely simulating, in fact, the symptoms of typhoid.

We must be on the look-out for the other signs, which, however, may be lacking—epistaxis, rose-coloured spots, which anyhow do not make their appearance until the eighth day; and the sero-reaction which, if positive, settles the question, but if negative merely leaves it open.

Albuminuria is commoner and more marked in typhoid fever than appendicitis, and the presence of albumen early in the case is not without significance. Then comes the blood examination, and its value is extreme. In non-complicated typhoid fever hypoleucocytosis is the rule; in appendicitis, especially when tending to suppuration, we find hyperleucocytosis. The existence of this hyperleucocytosis is a fact of the greatest importance in assisting us to arrive at a correct diagnosis. In my case it oscillated between 19,000 and 28,000, and this result, in the ascertained absence of any pleuro-pulmonary mischief or other focus of inflammation, militated strongly in favour of appendicitis. Of course, numerous examinations of the blood will be necessary for this information to possess its maximum value, but when the hyperleucocytosis persists and increases *pari passu* with the local mischief, there remains no room for doubt. Even after the first examination our views underwent a change, and sundry phenomena, previously ill-understood, were seen in a new light. The importance of this line of research at an early stage cannot be too strongly insisted upon, but we must bear in mind that hyperleucocytosis may be absent in certain cases of hyperseptic appendicitis, and that certain inflammatory complications of typhoid fever, apart from appendicitis, may, on the other hand, give rise thereto. We must therefore be guided by the symptoms as a whole, but in this whole the hæmatological data occupy a conspicuous place.

It may happen that typhoid fever and appendicitis set in together in such wise that their symptomatology becomes mixed; indeed, this association is by no means rare, especially in children. It may of course be objected that in this event we are not dealing with appendicitis properly so-called, but rather with appendicular lesions of typhoid origin. The result in any case is to mask the symptoms of typhoid fever. It sometimes happens that in the course of an ordinary attack of typhoid fever during which at no time has attention been called to the appendix, grave accidents may supervene presenting all the appearances of typhoid perforation, but due in fact to an overlooked appendicitis. On the other hand, we may recall the cases of "ambulatory" typhoid in which peritonitis suddenly supervenes. This is diagnosed as acute appendicitis, and laparotomy is performed, only to find a typhoid perforation—if indeed anything at all is discovered, for the perforation may be very minute, and situated high up in the small intestine.

In the last-named contingencies, the practical question of the proper course to follow can be stated without hesitation. We must act, and act at once, however obscure the diagnosis.

In the cases first dealt with—those in which we have to ask ourselves whether the case is one of typhoid fever or appendicitis—it is quite otherwise. Unquestionably when the accidents are not alarming, when there is no threatened generalisation, and when, in spite of the diarrhœa and the general

appearances, the pulse is of normal rapidity and is full and regular, we can take our time, and usually in a few days, with close observation, the problem will solve itself. It cannot be denied that the doctrine of immediate intervention in appendicitis has tended to increase the number of instances in which a healthy appendix has been removed from a typhoid patient in the initial stage. But there are cases in which the symptoms are so acute that we dare not delay, consequently, when in doubt, and in presence of pressing symptoms, it behoves us to operate, diagnosis or no diagnosis.

Note.—*A Clinical Lecture by a well-known teacher appears in each number of this journal.*

ORIGINAL PAPERS.

NOTES ON A CASE OF HYSTERECTOMY FOR FIBROMYOMA UNDER SPINAL ANALGESIA.

By J. H. SWANTON, M.D., M.Ch., R.U.I., M.R.C.P.Lond.
Obstetric Physician to the Kensington General Hospita. &cl,

The patient from whom this tumour was removed is forty-four years of age, and complained of pain in the left side, bearing down on walking, increasing frequency of micturition both by night as well as by day, and occasional attacks of diarrhœa. She had enteric fever when sixteen and small-pox some years later.

Menstruation began at fifteen; the periods being regular, every twenty-eight days and lasting seven days. Occasionally the discharge returned after two days' apparent cessation and lasted one day. The amount lost was excessive. There was severe pain one week before appearance of menses. Since marriage the pain has disappeared but the amount has not diminished. Intermenstrual leucorrhœa came on soon after marriage, and there was some uterine displacement for which a pessary had been worn.

She has been pregnant three times, and the youngest child is eight years of age. Her labours were severe, and she dates her present illness from the birth of the second child, when she had a flooding and was ill for three months. The abdominal wall moved equally on respiration, and a hard mass was felt above the pubes extending upwards and to the left for six centimetres. Some mucous polypi projected from the cervix; the fundus was directed forwards. An irregular hard mass occupied the upper part of the pouch of Douglas, which was continuous with that felt through the abdominal wall. The uterine cavity measured eight centimetres. She refused to have the tumour removed, and as an alternative curettage was performed. Within three months menorrhagia returned, and was treated medicinally with ergotine, adrenalin, cotarnine hydrochloride, and phthalate, hydrastin, each in turn affording temporary relief.

The symptoms increased in severity, hæmorrhage became greater, pain in left side now radiated down the left thigh and leg. Insomnia was constant.

In September last I found her anæmic from hæmorrhage, suffering from intense pain and insomnia. A presystolic murmur was heard over base of heart inside the nipple line. The uterine tumour now extended seventeen centimetres above the symphysis and pressed on rectum and sacral plexus posteriorly. Some mucous polypi protruded from the cervix.

Operation was advised, and patient was admitted to hospital early in October last. After consultation with the staff it was agreed that a general anæsthetic would probably end fatally, so it was decided to operate under spinal analgesia by the injection of one of the new amino-alcohols known as novocain.

The operation took place on October 14th. The patient sat on the operation table in a flexed position while a trocar and canula were passed into the space between the laminæ of the third and fourth lumbar vertebræ on the left side for about two centimetres. On withdrawing the trocar a few drops of cerebrospinal fluid escaped. At 11.14 a.m. three cubic centimetres of a 5 per cent. isotonic solution of .15 gramme of novocain and .00325 gramme of suprarenin borate was injected into the spinal canal. The patient then lay down and the pulse was observed to be 120.

At 11.28 *i.e.* fourteen minutes after injection, patient complained of pricking in her toes, but sensation was unimpaired and voluntary movement continued. This paræsthesia passed off in five minutes, and her pulse was 134. Another injection of 3 c.c. was given on right side at 11.40, and in four minutes sensation and movement of lower limbs were impaired. At 11.50, six minutes later, patient said her toes were "pricking something awful." At 11.57 the paræsthesia passed off and was followed by complete loss of sensation and voluntary movement in the lower extremities.

The pelvis was now raised into the Trendelenberg position, and in five minutes analgesia had extended to the level of the umbilicus. At 12.2 p.m. a median abdominal incision was made eight centimetres long which had to be enlarged, after peritoneum was opened, to deliver the tumour from the pelvis. The tumour was held up while the cervix was defined by thumb and forefinger of the left hand. The posterior vaginal wall was incised longitudinally for four centimetres over its attachment to the cervix, which was then seized by a strong vulsellum forceps and drawn upwards and backwards through the incision. The vaginal attachment was then cut through by scissors curved on the flat. The tumour was drawn upwards and forwards and separated from the bladder anteriorly, when the utero-vesical pouch was opened, leaving the tumour attached only by the broad ligaments.

These were now clamped through the infundibulopelvic ligament on each side down to the opening in the vaginal roof. The tumour and adnexa were then removed, the ligaments being tied in sections and vessels ligatured separately. The raw edges of peritoneum were united by a continuous suture of catgut.

During the preceding manipulations it was observed that at 12.14 p.m., twelve minutes after the operation commenced, the pulse was 96 and of low tension. At 12.20 a few mouthfuls of watery fluid were vomited, when pulse tension increased. At 12.22 patient complained of thirst, and took three mouthfuls of hot water and brandy. The tumour was removed at 12.30, and in five minutes afterwards the pulse was 96.

At 12.45 the patient had a further draught of water and brandy, the pulse was 116 and tension was increasing. There was no change in the facial aspect from the commencement of the operation.

When the vessels in the broad ligament were seized preliminary to ligature the patient complained of a twisting dragging pain, which also came on whenever the parietal layer of the peritoneum was drawn forward.

At 1 o'clock peristalsis began, the pulse became rapid and irregular, but within ten minutes was less frequent, full and regular.

Some nausea and straining came on, the intestines became distended so that suturing was delayed and interfered with. The patient was then put under anæthesia by A.C.E. mixture and the operation completed.

The subsequent convalescence was complicated by nausea, pain referred to umbilicus, and paralytic ileus, which disappeared after several turpentine enemata had been administered.

The patient was discharged on the 24th day and progress continues satisfactory.

The tumour weighs 1587.57 grammes, or 3½lb., and involves the posterior wall of the uterus, apparently commencing interstitially and soon involving the endometrium. The uterus is extended considerably and the cavity much enlarged. The tumour is a fibromyoma.

Spinal analgesia is likely to prove useful in gynæco-

logical and obstetrical cases where prompt operative interference is required, but owing to the existence of shock a general anæsthetic is contraindicated.

A CAUSE OF FATAL COLLAPSE AFTER PROLONGED ABDOMINAL OPERATIONS.

By R. H. HODGSON, M.D.DURH., M.R.C.S.ENG.

THE British Gynæcological Society is more concerned in abdominal operations and has done more to perfect the technique of abdominal surgery than any other society in London, but since there is no end to learning, may I suggest that the relative importance of the selection of an anæsthetic in long operations upon the abdomen is, I fear, too often overlooked, and the choice left to the anæsthetist, with the result that many cases of fatal collapse are erroneously assigned to the length of the operation rather than the unsuitable anæsthetic. No one would wish to place the cause of a fatal termination of an operation upon the shoulders of the anæsthetist, nor would any operator desire to share the feeling of sorrow, at the loss of his patient, by division of responsibility. The operator is, and must be, the unfortunate one upon whom rests the weight of the disaster. It, therefore, behoves him to give careful consideration to the question which is the most suitable anæsthetic, in each case, for the safety of the patient, bearing in mind that no one, before opening the abdomen, can say with certainty, that the operation will not be a long one. I feel fairly confident that if sufficient statistics were available, we should find that, comparatively, many more deaths followed long operations upon the abdomen when the anæsthetic was ether than when it was chloroform, and I am constrained to think so for many reasons which I hope to be able to lay before you in a sufficiently lucid manner to cause many of my hearers, if doubtful of my views, to at least give the subject their serious consideration.

If we carefully observe the action of Alcohol, Ether and Choloroform upon the human body when living and when upon the *post-mortem* table, we will find that alcohol and ether have actions so similar that it will not be necessary to differentiate between them. The difference between chloroform and ether, however, is very great upon the body. On observing the living heart we find that its frequency of action is increased by ether and decreased by chloroform. That its power is increased by ether and decreased by chloroform. That the volume of blood passing through its cavities is decreased by ether and increased by chloroform. That when death takes place from ether the heart ceases in diastole, and when from chloroform in systole. Few exceptions indeed can be found to these states, and they can mostly be accounted for by efforts to resuscitate the patient, such as artificial respiration and inversion of the body.

Generally speaking, we may say that ether expends and chloroform husbands nerve energy. That ether causes capillary contraction and chloroform capillary dilatation, and that both cause death by congestion and consequent functional insufficiency of the lungs, may be explained by the assumption that ether contracting the capillaries and thereby inducing increased heart action, capillary congestion results, and that chloroform by relaxing the capillaries depletes the heart which, becoming gradually slower, weaker, and more empty, permits stasis of blood in the lungs. If the administration of chloroform be farther continued, the lungs, overcharged with poisoned blood, cease to work, and the patient dies with an empty heart, that organ having made its last stroke after the lungs have ceased to respire. This chloroform congestion of the lungs is of the nature of hypostasis. But the congestion of the lungs under ether is a capillary engorgement under pressure, with the result that the patient dies of enervated heart action brought about by an endeavour on its part to force the circulation. Hence we find in addition to the capillary congestion an exudation around the capillaries and into the air vesicles and lungs generally.

It is this exudation which is the most difficult obstacle to restoration in threatened death from ether anæsthesia, and the one from which the patient is liable to collapse many hours after having been returned to bed and having recovered consciousness.

From the foregoing remarks we may assume that both chloroform and ether produce anæsthesia by impeding the due elimination by the lungs of certain poisonous substances. Whether those substances be gases wholly or in part it is difficult to say, but it is their accumulation which is the narcotising agent. Neither chloroform nor ether *per se* could cause that condition to supervene in the quantities necessary to produce anæsthesia unless aided by something else. Chloroform and ether are the collectors of the narcotising agents.

Dr. F. W. Hewett says: "Junker's inhaler does not necessarily rob chloroform of its dangers." This lends weight to my view that the danger clearly must arise from something other than chloroform, since the administration by this apparatus needs but such a small quantity of chloroform to produce anæsthesia. Taken by the mouth in like quantities, these drugs have little effect. They thus differ from hydrocyanic acid, which when inhaled appears capable of destroying life unaided and in far too short a time to admit of death from suffocation. Theoretically when the capillaries of the lungs are becoming stagnated by ether contraction, and the heart consequently full, chloroform should be the antidote by relaxing the capillaries and thus relieving the heart, but by the time that ether has gone so far, the heart is on the verge of collapse from exhaustion due to its poisoned blood supply and its struggle to force the circulation. By the smaller amount of blood passing through the capillaries during ether administration and the cooling nature of that drug, the body becomes markedly cold, and, indeed, has a frozen feel in those who are unfortunately about to succumb to its administration. Dr. F. W. Hewett, when speaking of people who suffer from dyspnœa when not under an anæsthetic, says: "Generally speaking, the presence of even moderate dyspnœa calls for chloroform."

Here he recognises that chloroform interferes less with the aeration of blood in the lungs than does ether. Chloroform appears to ease the dyspnœa by allowing a freer flow of blood through the proper channels.

Further, the same author says: "In advanced heart disease ether should be avoided." Here he evidently considers that ether puts stress upon the enfeebled heart, exciting it beyond endurance in its effort to force the blood through the contracted capillaries. We do not want, in an engorged lung, contracted capillaries to prevent the free circulation.

Whilst upon the capillary irritation and contraction, I hope that I may be excused for remarking in a gynæcological society that this raises in my mind some doubt as to the advisability of administering oxygen in pneumonia. In years past it was not unusual to keep a patient under chloroform for as long as two days in the hope of curing an aneurism. If any one has made the attempt to keep a patient under ether for two days it would be as well not to enquire the result of that operation.

If we examine for ourselves those cases of deaths occurring during chloroform administration with which we are personally acquainted, I think we shall find that each has been accompanied by one at least of the following circumstances—the administrator was inexperienced or in a hurry to get the patient under, the surgeon was in a hurry to begin or get away, or a friend was keeping up a conversation in the anæsthetist's ear. A chloroformist told me that through the many thousands of major operations in which he had given chloroform he had never had a death. I believe that man was both truthful and had a good memory, and I never saw his eye off his patient whilst he was administering chloroform. Anæsthetists abound, but chloroformists of high perfection in its administration are few, and the constant laudation of the ever springing up of supposed safe and new anæsthetics only tends to perpetuate the desire to avoid the use of an anæsthetic believed to be most

dangerous. The great objection to chloroform appears to be the fact that if once the heart is allowed to become completely empty, then recovery from impending death is almost hopeless. Threatened death from ether narcosis does give time to attempt the restoration of the patient, but how many recover after unequivocal signs of heart failure, under this drug, is a question which must be left for statistics to settle, if they can show differentiation between death from true surgical shock and the inability of the heart to maintain the circulation whilst the absorption of the exudation surrounding the capillaries and invading the air vesicles is proceeding. Ether is supposed to render complete anæsthesia of the nerves of sensation.

The fatal collapse of a patient after a long and difficult operation which has at last succeeded surgically, is one of the most trying and disheartening events in a surgeon's life; but this is of minor importance, since the surgeon will probably outlive it, and with the exception of perhaps the addition of a few more grey hairs to his head, will show no outward sign of the grief it has caused him. The patient, however, has gone, and although in some, if not many, of the cases requiring serious operations, this termination may, so far as the patient is concerned, be the best for him individually, yet there may be those left behind deprived of the one most dear to them and often the one whose loss means their worldly downfall. If, therefore, this paper may have seemed somewhat irrelevant in a society devoted almost wholly to surgical work, I trust that I may be excused for thus occupying your time on the ground which I have endeavoured to show that the anæsthesia and the operation should be inseparable from the operator.

NOTES FROM THE FRAUENKLINIKS OF HEIDELBERG AND FREIBURG. (a)

By H. MACNAUGHTON-JONES, M.D.

PART I.

"Bene diagnoscit, bene curat." This is the aphoristic motto that all who enter Professor Krönig's operating theatre may read. Surely none could be more aptly chosen, and no words could speak more eloquently to the gynæcologist. Great technical skill and manipulative dexterity are the handmaids of a particular technique, but justification for the risk involved in the carrying out of any predetermined method and the responsibility incurred in advising operative interference must in both cases depend on accurate diagnosis—*early* diagnosis, for assuredly the great blot on the page of progress in gynæcological practice is the casual, procrastinating habits of us doctors. With all our talk, writings, and discussions, pathological displays and operative triumphs, are we getting nearer the supreme aim of every surgeon—early recognition of the abnormal, early detection of signs that throw light on symptoms, early acceptance of the grave responsibility cast upon us by that first appeal made to us for relief of symptoms, it matters not how slight those symptoms may be? It were well that those terms (too often the cloak for carelessness, indifference, or ignorance!)—"neuroses," "neurotic," "neurasthenia," "hysterical," were dead phrases to most of us. Pain would not then be ignored, a discharge trifled with, a locomotor difficulty assigned to gout or rheumatism, a pregnancy confounded with a cystoma, or *vice versa*; nor should we read of revelations following the discovery of a loose kidney, or death in a few days from a fulminating appendicitis. We should not hear so often of "inoperable carcinoma," of ruptured pyo-salpinx, of fatal collapse from ectopic gestation, of two to three hours operative procedures, ending in early collapse or sepsis.

But assuredly the saddest of all the consequences of neglect of early diagnosis is that which follows in the wake of cancer and cancerous infection. While we are still groping in the dark for a cure, waiting on pathological research, and following the *ignis fatuus* of some advertised therapeutical boom, we let slip the time for applying the only cure we as yet know of—viz., early and free operation. If this society, now in its dying hours, sent out no other message, trumpet-tongued, to the profession, or left no other legacy as the outcome of its accumulated experiences than this: "Diagnose cancer early," it would have justified its existence, and the initiators of it, dead or living, would have earned our gratitude

Medullary Anæsthesia.—Before referring to the kliniks of Heidelberg and Freiburg, I desire to touch on the question of spinal anæsthesia, inasmuch as it was in regard to what I saw of this new movement in operative gynæcology that I was most interested. There can be no doubt that the man deserving the greatest credit for the introduction of this method of securing narcosis is Bier, who, in 1899, first employed cocaine for this purpose, unaware and quite independent of Corning's treatment of spinal affections with intradural injections of the same drug. Bier (like Simpson and Duncan in the case of chloroform) experimented on himself and his assistant Hildebrandt, and both experienced several of the unpleasant after-effects. Results were not encouraging, but Tuffier, in France, followed in 1900 with 250 operations, of which 142 were laparotomies. Of 1708 cases reported by Hahn in 1901, eight had died, and Morton, of San Francisco, reported 673 operations under cocaine. In 1904 Bier made the next great advance in the addition of the antidotal adrenalin, and in substituting stovain (first employed by Sonnenburg) for cocaine. Doenitz was associated with Bier in his work.

Since 1904 a host of workers have been giving their experiences. These have turned mainly on the relative value of the drugs used—leucaine, tropacocaine, stovain and novocain, the last three being those commonly used; on the advantages and disadvantages of this anæsthetisation as compared with general anæsthesia and chloroform; on the dangers associated with it, and how to avoid them; on the precautions to be taken in, and the best method of administration of, the anæsthetic; on the employment of it for operations above the level of the umbilicus; on its suitability in particular cases; on the disadvantages of retention of consciousness; on the combination of scopolamin and morphia narcosis with the use of either stovain or novocain, as introduced by Kronig. A few words on each of these questions may not be amiss.

First, as to the relation of the value of the drugs employed. Leucaine (Jedlickal and Mayer) has been abandoned (Engelmann). Tropacocaine is still employed by Doenitz for operations above the level of the umbilicus. He reports on it most favourably in combination with scopolamin and morphia as accessory narcotics. The patient is not conscious, and the pelvis need not necessarily be elevated. Of the three, tropacocaine seems to Doederlein to be very far the best. He thinks also the toxic effects are less after it.

Schroeter reported a failure of thirteen out of eighty-six administrations of stovain; one case was resuscitated from collapse by cardiac massage and artificial respiration, but in that there had been re-injection of the spinal fluid several times. He also uses novocain. Professor Leyer considers that medullary anæsthesia should not be used save where infiltration anæsthesia or perineural cannot be carried out, or where general narcosis is contra-indicated. In two out of nine cases there was serious collapse from novocain.

Veit (Halle) prefers stovain, a smaller quantity being required to secure anæsthesia. Sonnenburg now uses novocain and suprarenin. In 603 cases (114 stovain and 135 stovain-adrenalin) there were five deaths. Neumann (Berlin) uses both stovain and novocain with suprarenin. Koenig (Altona) prefers stovain-Billon to the stovain-Riedel and to novocain.

Franz (Jena) uses novocain and suprarenin and morphine-scopolamin narcosis. He has had 180 operations without a death, or any threatening symptoms.

This is sufficient to show that there is not complete unanimity as to the best of these three, and it would appear that there is not much to choose as between

(a) Read at the British Gynæcological Society, on Dec. 13th, 1906.

the stovain and novocain, though preference seems now to be given to the latter.

As to the precautions to be taken in the administration, these are included in my ref rences to the kliniks. Purity of drug is essential, and it is questionable if it should not be as fresh as it is possible to have it.

Dangers Associated with the Practice of Spinal Anæsthesia.—The principal of these are arrest of respiration from involvement of the medulla, and the motor nerves; collapse immediately during or after operation; spinal paralysis; sepsis. All of these have been causes of death. Care in carrying out the strictest aseptic details, deliberation in selection of the spot for puncture, slowness of injection, not too rapid elevation of the pelvis, the combination of the scopolamin and morphia narcoses, are most necessary.

There can be no question that the risk is greater when the punctures are made higher in the cord than the umbilical level. We have not, however, to say to this here.

What, then, are the advantages claimed for this method over that of chloroform and general anæsthesia by other means?

They may be briefly and categorically stated thus:—Chloroform is avoided in cases in which general anæsthesia is contra-indicated, in cardiac diseases and in arterio-sclerotic states; the possibility of deferred death from chloroform in prolonged administration is not to be feared, the action of the abdominal muscles in abdominal operations is not encountered, the frequent post-operative effects of chloroform and ether are absent.

What, now, are the disadvantages? Firstly

The Perception of the Operation.—Surgeons are by no means unanimous as to the benefit or the contrary of retained consciousness during a long abdominal operation. Certain disadvantages will strike you at once.

The Chance of Vomiting.—This has often taken place during, and has continued after, operation, with all the drugs used. It is not so common now, owing possibly to better administration, and in no single case did I see it occur at either klinik.

Movement of the Bowel.—This, in operations on the perineum, or plastic vaginal operations, makes the administration somewhat risky in such cases. I did not see it occur, though I witnessed several plastic operations.

Insufficient Narcosis.—This may be due to dispersion of the drug and dilution in the spinal canal, with failure in the anæsthesia. Strong traction of the pelvic viscera tends to interfere with it.

Risk of Collapse.—This appears beyond doubt to be a risk that must be estimated in these cases. Possibly an injection of strychnine and atropine, given half an hour before the operation, may prevent this. The addition of the adrenalin solution has materially lessened it.

Respiratory Paralysis.—These cases have been very few comparatively. Too rapid injection and raising of the pelvis, or injury to the anterior roots, may predispose to it.

Injury to the Motor Nerves during Injection.—This will be avoided by care in the puncturing.

Headache.—This follows in a certain number of cases under all the drugs, and with every precaution.

Sepsis and Impurity of Drugs.—These drawbacks have to be met by strictest asepsis, and the guarantee of the chemists. This is but a very remote danger.

Just a word on the scopolamin, morphine, and chloroform anæsthesia. Scopolamin is, as you know identical with hyoscine. In carrying out this method the scopolamin—1-64th to 1-200th of a grain combined with ¼ to ½ grain of morphia is injected subcutaneously the night before the operation, and repeated an hour before it takes place. Chloroform or ether is then given in the quantity required. Take he following case as an example:—

A patient, æt. 70, was carried into my study after a long railway journey, in a collapsed condition. In her state it was impossible to make an examination. I ascertained, however, that there was a fœtid growth protruding from the vagina, and I drew off five pints of urine from the bladder. The right leg was affected with neuritis, for which she had been in bed six weeks. By nutrient enemata and injections of strychnine, she was kept going for three days. On the night of the third day she had a scopolamin and morphia injection. On the following morning, two hours before the operation, she had another. One hour before the operation a strychnine and atropine injection was given (a plan I have always adopted in any serious abdominal case since reading the experiments of Prof. Schaeffer and Mr. Scharlieb). I removed the growth, which evidently sprang from the anterior vaginal wall in front of the trigone and then invaded the cellular tissue, spreading high up into the left fornix. Both sides were freely cauterised. It has proved to be a carcinoma.

Mr. Scharlieb, who gave the patient chloroform, informs me she was put under with rather less than half a drachm of a 10 per cent. alcohol, and 90 per cent. chloroform mixture, and kept under with about 3 drachms of pure chloroform, with a Vernon-Harcourt regulator; mostly between 0.4 and 0.6 of chloroform. She did not suffer after the operation, and passed a perfectly quiet day and night without any sickness.

SOME RECENT LITERATURE.

Medizinische Klinik. Professor E. Brandenburg, Berlin. September, 1906. 37.

Reports from the Kliniks of:—Franz (Jena), Sonnenburg (Berlin), Lexer (Koenigsberg), Neumann (Berlin), V. Rosthorn (Heidelberg), Friedrich (Griefswald), Martin (Griefswald), Doederlein (Tuebingen).

Resume of the entire subject of "Spinal Anæsthesia," by K. Baisch. See also Summary, *Brit. Gyn. Journ.*, Vol. XVII., 26, 120. Vol. XVIII., 181. Vol. XX., 73-74, 127. Vol. XXI., 177, 51.

THE OUT-PATIENTS' ROOM.

PADDINGTON GREEN CHILDREN'S HOSPITAL.

Case of Dorsal Caries.

By A. EDMUNDS, M.S., F.R.C.S.

AMONGST the out-patients was the case of a female child, æt. 5, who had been under treatment for the past eighteen months. When she first presented herself at the hospital she exhibited the characteristic symptoms of spinal tuberculosis in the mid-dorsal region. In her particular case the pain was not very acute, but there was a well-marked deformity, and there was definite rigidity. The characteristic deformity could be easily elicited by attempting to flex the spine, thus bringing into relief the acute break in the curve at the seat of the disease. Rigidity could be best demonstrated, Mr. Edmunds pointed out, by placing three fingers on the tips of three adjacent spinous processes; keeping each finger carefully in place over the corresponding spinous processes, movements of the spinous processes upon each other would be readily manifested by the separation or approximation of the fingers. The child showed no sign of abscess and no sign of paralysis. It was, therefore, a typical case of spinal caries in a comparatively early and therefore hopeful condition. The number of appliances, he said, which have been invented for spinal caries was enormous, and there were few without drawbacks. His own routine treatment for spinal caries in very young children consists in keeping the child flat upon a hard mattress; he instructs the parents of the child to procure a board about three feet long by about eighteen inches wide; upon this are placed two or three layers of dressmaker's cotton wool, and the whole covered by a blanket. The child is kept in a flannel nightgown, which is

divided down the back, so that it can be tucked under the sides of the child without disturbing the infant; shoulder-straps are fixed to keep the child's shoulders on the board; blankets and rugs can be wrapped round the child and the board. The little patient can remain quite comfortably on this apparatus as long as necessary—usually for about twelve months. It can be washed with a minimum of disturbance, and can be carried about the house or taken out of doors without danger to its spine. As regards the excretions, any small dish, for example a small pie-dish, can be used. The whole of this apparatus can be manufactured for about 1s. 6d., and it has the advantage over the more elaborate forms of apparatus that, being made by the parents, it can also be kept in order by them. It is a very common disappointment, he thought, to find an expensive piece of apparatus put on wrongly, broken and bent, so that it is perfectly useless. The method he had just described he illustrated in the out-patient room by means of models. This board is not so good for children over four years old, and for these he prefers a Phelp's box. This most excellent appliance is sometimes regarded with suspicion, owing probably to the faulty patterns which are sometimes made. The points to be attended to are: (1) The box must be long enough to allow for growing—about six inches longer than the patient; (2) the divided portion of the box must be so arranged as to keep the child's legs abducted; (3) the piece of wood which comes up on the inner side of the leg is generally made too broad; it should be planed down, so that where it reaches the opening round the perineum it is only about half an inch wide. Unless this is done it is impossble to bandage the child firmly in. The box should be lined with thin firm cushions made of American cloth, which should be encased in washing covers. The child can be taken out once a week and washed on a bed. These cases soon learn to keep their whole back so rigid that the disturbance produced by lifting the child out of the box does no harm. After the child has been kept in the box for a sufficient time, Mr. Edmunds was in the habit of ordering the appliance which the patient under observation was now wearing—namely, a tailor brace. The principle of this last was that there was a firm pelvic belt, kept in position by perineal straps; to this are rivetted a pair of steel bars, which pass up one on each side of the spine, following its curves. These steel bars terminate above the middle of the clavicles about on a level with the posterior border of the sterno-mastoids, and bear at their end an arrangement of straps by means of which the shoulders are held back to the supports, transferring the weight of the trunk and the muscular pull from the diseased bodies of the vertebræ to the sound neural arches. An abdominal belt can be added to steady the whole. With these three types of apparatus one can, he considered, manage most cases of spinal caries. While the all-important rest for the vertebral bodies is procured, one should not neglect hygienic measures. Fresh air is as valuable for these as for other tuberculous conditions. As regards internal drugs, he was in the habit of always giving cod-liver oil unless it disagreed with the patient.

OPERATING THEATRES.

ROYAL FREE HOSPITAL.

Strangulation by Meckel's Diverticulum.—Mr. Wilmott Evans operated on a man, æt. 24, who had been admitted suffering from acute abdominal pain. The patient had always been well, and had never had any similar attack before. On the morning of the day of admission he had suddenly felt an acute pain in the region of the umbilicus. The pain steadily grew worse, and about four hours after its commencement he began to vomit; the vomiting continued until the time of admission. The bowels had been acting normally, and an ordinary motion occurred soon after the commencement of the pain, but for the last few hours he had not passed even any flatus. On examination he was seen to be a well-built and well-nourished man, his pulse was 92, and his temperature normal. The abdomen was distended, and it was noticed that the distension was not uniform, the middle portion of the abdomen being especially prominent, while the flanks were flattened. Palpation revealed nothing, and on percussion the abdomen was everywhere resonant, excepting for the normal dulness over the liver. He complained of pain a little to the right of and below the umbilicus. His vomiting persisted, but there was nothing specially noticeable about the matters vomited. Acute intestinal obstruction was diagnosed, and it was suggested that the obstruction was probably caused by some peritoneal band. The patient was anæsthetised, and, the abdomen having been cleansed and a catheter passed to empty the bladder, a three-inch incision was made in the middle line between the umbilicus and the pubes. On dividing the peritoneum some highly distended small intestine presented itself, and also towards the right side was visible some collapsed bowel; the collapsed bowel, which was evidently ileum near the ileo-cæcal valve, was followed upwards until it was found to join a piece of distended gut, and at the place of union a narrow tense band constricted the bowel. At this stage it could not be seen where this band was attached; the band was carefully divided, a pair of pressure forceps being placed on each side of the point of division. As soon as the band was cut through, gas passed from the distended portion to that which had been collapsed, and the bowel became uniform in appearance, the situation of the constriction being, however, still visible as a slightly depressed line. Next the attachments of the portions of the constricting band were examined; one was found to pass upwards to the umbilicus and the other to pass downwards to a part of the small intestine a few inches above the place where the constriction had occurred; this was some three feet from the ileo-cæcal valve. The lower part of the constricting band was dilated and formed a diverticulum from the bowel. It was clear, Mr. Evans pointed out, that this was a Meckel's diverticulum, which had been attached to the umbilicus, and had been in part obliterated. The portions of the band were removed, the diverticulum was dissected off, the edges were turned in, and the wound in the bowel closed by Lembert's sutures. The abdomen was closed in the ordinary way. Mr. Evans said that the sudden onset of the abdominal pain, the vomiting and the distension of the abdomen, combined with the inability to pass flatus, all pointed to acute obstruction of the band, also that this obstruction was in the small intestine was shown by two facts:—(1) the sudden onset, which was hardly ever seen in obstruction of the large intestine, though occasionally in volvulus of the sigmoid flexure the symptoms may suddenly become acute; (2) the shape of the distended abdomen showed that only the small intestine was dilated, and that the large intestine was empty. In such a condition of things immediate operation was the only possible treatment. With regard to the operation itself, little, he thought, could be said. When, on opening the abdomen, portions of dilated and compressed bowel were visible, it was clear that the site of constriction must be between them. It was much easier, he said,

to manipulate collapsed bowel; therefore, as a rule, it was better to follow the collapsed bowel upwards to the point of obstruction. In this case, the obstruction had not continued long enough to make it at all probable that any permanent harm had been done to the wall of the intestine, and therefore that part needed no treatment. It was considered advisable, he remarked, to remove the remains of the constricting band, in case at a later period strangulation should occur.

The patient made an uninterrupted recovery.

OPERATION FOR THE CURE OF A FÆCAL FISTULA.—Mr. T. P. LEGG operated on a young woman, æt. about 25, for the cure of a fæcal fistula in the right groin; the fistula had been present for many years. She gave a history of having had a lump which was tender and painful in the upper and inner part of Scarpa's triangle. She had been to another hospital, where a knife had been put into the swelling, and a fæcal discharge had continued ever since. When admitted to the Royal Free Hospital, there was a fæcal fistula in the upper part of Scarpa's triangle, discharging a great deal of greenish semi-solid, very irritating fluid, so that the whole of the lower part of the abdomen and the right thigh as low as the knee were excoriated and eczematous. Her general health was good, she had not lost much flesh, and there was nothing abnormal to feel in the right iliac fossa, or in any other part of the abdomen. Rectal and vaginal examinations were also negative. She was kept in bed for some time, and means taken to improve the local condition of the skin before proceeding to operate. At the operation a curved incision was made over the lower part of the right rectus muscle, and a bougie passed through the fistulous opening to serve as guide to the opening into the intestine with which the sinus communicated. On opening the peritoneal cavity no adhesions were found except where the fistula opened into the bowel; the sinus was cut across and the loop of intestine brought up into the incision. The opening was situated on the convex border of the bowel. The part of the intestine beyond the fistulous opening was somewhat contracted, and there was a well-marked spur, which had served to direct the intestinal contents to the surface. The edges of the aperture were refreshed, and then sewn up by two layers of sutures; the sinus was scraped with a sharp spoon, and a drainage tube placed in it. The abdominal incision was completely closed after the intestine had been replaced. Mr. Legg said that this fistula was probably the result of a strangulated hernia having been mistaken for a mass of inflamed glands; most likely the hernia had become considerably inflamed, and there being no impulse on coughing it was easy to see how without care such a mistake could be made: hence the importance of exercising great care in opening all inflamed swellings in the groin, especially in women, in whom the source of the bubo may not be as obvious as it generally is in men. The situation of this fistulous opening could be diagnosed, he thought, as being in the lower part of the small intestine, because in the first place the patient's general health had remained so good, and secondly by the character of the discharge: in fæcal fistula high up in the small intestine the patient as a rule emaciates very rapidly. With regard to the discharge, it was semi-solid, and not so irritating to the skin as when it comes from the upper part of the small intestine. The chief danger during the operation, he pointed out, was septic infection; this can be reduced to a minimum by adopting the plan of opening the abdomen as in this case, and by carefully plugging the fistulous opening. The difficulties of the operation, he considered, were:—First to find the affected coil, and secondly to separate the adhesions without further damaging the wall of the gut. It was interesting to notice, he remarked, that although this condition had been going on for so long, there were few adhesions, the explanation being that the fistula was the result of a strangulated hernia, and not due to any inflammatory state, such as tuberculous peritonitis, or chronic appendicitis. The method of closure of the intestinal aperture adopted in this case was, he said, satisfactory if the hole is comparatively small and in the long axis of the bowel wall; stenosis under these conditions is not likely to subsequently occur. A larger aperture, especially if the intestinal wall itself was rotten or friable, demanded excision of the involved portion, and end-to-end union of the resected loop of bowel.

The patient made an uninterrupted recovery, and left the hospital three weeks after operation. It was interesting to observe, Mr. Legg subsequently pointed out, how quickly the skin recovered when the fistulous opening was closed; the sinus, too, healed up rapidly.

TRANSACTIONS OF SOCIETIES.

BRITISH GYNÆCOLOGICAL SOCIETY.

MEETING HELD THURSDAY, DECEMBER 13TH, 1906.

The President, MR. BOWREMAN JESSETT, F.R.C.S., in the Chair.

MR. FURNEAUX JORDAN made a further communication on the specimens shown at the last meeting. The uterine fibroid had been carefully examined by the pathologist in Birmingham, and stated to be an œdematous fibroid.

SPECIMENS.

Dr. SWANTON showed a uterus removed by abdominal hysterectomy for fibroma under spinal analgesia. (which will be found on page 693).

Mr. CHARLES RYALL showed

A UTERUS REMOVED UNDER SPINAL ANALGESIA FOR HYPERPLASTIC ENDOMETRITIS.

The patient was aged thirty, and was suffering from menorrhagia. She had been in several hospitals for the same trouble, and had been curetted. On examination the uterus was found to be large and patulous, almost admitting the tip of the index finger. After preliminary preparation abdominal hysterectomy was carried out on November 7th. She was injected with one and three-quarter ampulla of 5 per cent. novocain solution, and analgesia was established in about ten minutes. The whole operation took exactly forty-one minutes. During the operation the patient did not complain of any actual pain, but she stated she felt something being pulled when he seized the uterus and drew it up to the abdominal wound. She was nervous and upset, and had some vomiting, causing the intestines to bulge into the wound, so that he was compelled to desist until the attack passed off. He could not say at the moment how long the analgesia lasted, but she made an uninterrupted recovery. He did not know enough about spinal analgesia to pass an opinion on it at present. His first experience of it was in Paris one and a half years ago, when he saw a patient have abdominal hysterectomy performed under stovain. At that time he was not very favourably impressed with it. The patient's general condition in the present case was bad, and his brother, Mr. Canny Ryall, suggested that he should do the operation under novocain. So far everything in connection with the matter had been exceedingly satisfactory. He thought there were a certain number of cases in which spinal analgesia was preferable. Another set of suitable cases were those where there

was some pathological pulmonary condition, such as pneumonia. Another class was that in which there were serious lesions of the heart. So far he was not prepared to say that he considered it a suitable routine method, but he considered it most useful. Shock was said to be diminished by using spinal analgesia. Shock was much better understood now than formerly, particularly in abdominal surgery.

Dr. HODGSON read a paper on

A CAUSE OF FATAL COLLAPSE AFTER PROLONGED ABDOMINAL OPERATIONS.

(which will be found on page 694).

Mr. SPANTON dissented from the view that the surgeon should choose the anæsthetic. He thought that after the surgeon had stated the nature of the operation and the length of time it would be likely to take, the choice of the anæsthetic should be left to the anæsthetist. He agreed that the surgeon would be responsible for a fatality if the operation were unduly prolonged, as that added to the shock, and also it might be necessary for the surgeon to suggest a change in the anæsthetic.

Mr. FURNEAUX JORDAN endorsed the remarks of Mr. Spanton that the surgeon should not be held responsible for the anæsthetic used. Legally the anæsthetist was responsible, not the surgeon. He doubted whether there were many cases of fatal collapse in abdominal operations. He took it that if a patient died suddenly after an operation, in the vast majority of cases it would be found that there had been hæmorrhage, or other cause for the death apart from shock or collapse. With regard to the choice of an anæsthetic, for many years the Birmingham Hospital for Women had used an anæsthetic which was extremely simple and easy to give, and gave excellent results. It had only one drawback, and that was anæsthesia was produced slowly, as eight or nine minutes were required. It was a mixture of one of chloroform to two of ether, in a Clover's inhaler without the bag, and given so as to exclude the air underneath the face-piece. The patient went under anæsthesia easily. Little sickness had been noticed after its administration, and it could be given for any length of time. Personally he had found it invaluable. He would very much regret to see a return to chloroform as an anæsthetic. He believed chloroform should not be used as an anæsthetic unless there were special indications for it.

Mr. CHARLES RYALL said that the surgeon was responsible for the anæsthetist, and the anæsthetist for the form of anæsthetic he employed. If death happened under chloroform it did so at once, whereas ether was responsible for certain complications of a pulmonary character, which occurred at a remote period after the operation. Fatal collapse always followed prolonged operations, but with improved technique one could get over that to a large extent. There was frequently more waste of time at operations than there need be. He believed the risk was not in an overdose of the anæsthetic, but in giving too little of it. By adopting every means of saving time in operations, and taking care that the patient was deeply anæsthetised, shock would be greatly diminished. One great cause of shock was handling of the intestines and other parts.

Mr. STANMORE BISHOP pointed out that the administration of anæsthetics was now a separate and expert art. A man was either an anæsthetist or he was a surgeon, and he held very strongly that neither man should interfere with the other—that the surgeon should not consider it his duty, after he had chosen a fully qualified and thoroughly reliable anæsthetist, to dictate to him as to his choice of anæsthetic. With regard to the question of shock following prolonged operations, he thought that rapidity of operating had become to a certain extent a fetish, which men were inclined to magnify unnecessarily.

Dr. HODGSON, in reply, questioned whether it was right to leave the choice of the anæsthetic to the anæsthetist, as the public employed a surgeon to do the operation and save the patient, and they did not anticipate that the surgeon was going to hand over the safety of that patient to a stranger. He held that the surgeon was morally responsible, whatever took place. There was no doubt that unfavourable symptoms occurred some time after an operation, for which he considered the surgeon responsible. With regard to the administration of chloroform *versus* ether, when ether was brought into use thirty years ago it was supposed that nobody would die as a result of its administration, and it was largely used at St. Bartholomew's Hospital. But since that time ether had been less employed, and now was not used there more than 250 times in the year. Doubts had been expressed whether many people did actually die from shock or collapse following operation. Chloroform was safe if one had competent men to administer it.

Mr. H. MACNAUGHTON-JONES read

NOTES FROM THE WOMEN'S CLINICS OF HEIDELBERG AND FREIBURG,

with illustrations by the epidiascope shown by Dr. Macnaughton-Jones and Mr. Overy (which will be found on page 695).

The PRESIDENT said that the society had had placed before it most interesting papers and specimens from Dr. Spanton, Dr. Hodgson, and Mr. Charles Ryall, on which he invited discussion.

Mr. CANNY RYALL said that his experience in the use of spinal analgesia was founded upon some thirty or forty cases, and the conclusion he arrived at was that he would never think of using a general anæsthetic for an operation below the level of the diaphragm if he had "Novocain" at hand. He had been interested to hear the description of the method adopted abroad; it was not the best. He found the first necessity was to withdraw from the spinal canal such a quantity of fluid as it was proposed to inject of the spinal analgesic. He took care not to mix his novocain with spinal fluid. In any operation involving the lower limb he gave 5 c.c. of the 2 per cent. solution of novocain and suprarenin. For an abdominal operation, 10 c.c. of the same strength, after removing 10 c.c. of cerebro-spinal fluid. He believed the whole success of the procedure was due to the removal of cerebro-spinal fluid. None of the patients up to the present time had died, and two of the cases were quite cured. Three weeks ago he removed the rectum and part of the sigmoid flexure after excising the coccyx and part of the sacrum, and used spinal analgesia, and the operation lasted under an hour, and when the wife and daughter were brought in to interview the patient the man had a smile on his face, so that his relatives scarcely believed that the operation had been done. So that in such a very formidable operation as Kraske's, there was an absence of shock, though altogether the patient was under the influence of the drug six hours. He had gone on from that day to the present without a bad symptom. So there must be something good in spinal analgesia. In addition, he had performed appendicectomies, many operations on the lower limb and radical cures of hernia, and up to the present with no ill effect. The fact which impressed him most particularly was the absence of shock. He had not used stovain. One reason for that was that if applied to mucous membranes it was apt to cause sloughing. He had applied novocain and closely watched its effects on the mucous membrane of the mouth and nose, and in urethral work and cystoscopic work, but he had not seen any such effects following its use. He had nothing but praise for novocain, and he would not think of using a general anæsthetic after the experience he had had with novocain. Patients who had it rarely suffered from sickness afterwards, and a few only had headache.

Mr. SPANTON said he had no experience of spinal analgesia himself, but one approached a new matter of that kind with an open mind. It had been the fate of all anæsthetics when first introduced to encounter a considerable amount of opposition. Still it seemed necessary to proceed with considerable care in such a matter, because he gathered that five deaths had occurred from anæsthesia so induced in the cases abroad at one of the clinics referred to, and that there were two deaths in 380 cases at Freiburg, which was a high percentage of mortality. They were told also that in most of the cases which occurred there,

vomiting took place. One of the drawbacks of general anæsthetics in abdominal operations was vomiting. When one considered that only 500 cases had been done at Freiburg and there had been two deaths, there must not be too much haste in adopting it. He had not the same dread of general anæsthetics as some, because he had seen many instances very similar to the one which was quoted where the condition of the patient was so extreme that the anæsthetist did not care to give any anæsthetic whatever.

Dr. HERBERT SCHARLIEB spoke as a mere anæsthetist, and said stovain, novocain, etc., had come to stop, and it was useless and unscientific to take up an attitude of hostility towards them. They are very excellent and eminently suitable drugs to be employed in certain cases, but they had the decided disadvantage of being only analgesics, not anæsthetics. The patients lose the sensation of pain, but they are aware of every touch. This must be a decided disadvantage to the operator when the patient is highly nervous or imaginative. Such a patient might move at an awkward moment, and certainly might experience a good deal of mental shock. One of the objections to a general anæsthetic is its lethality immediate or remote—on the table or after the operation is well over. He held that the lethality of chloroform (at any rate during its administration) was wholly due to improper dosage. Chloroform being so safe (when properly administered and adequately guarded), he doubted the other methods of local or spinal anæsthesia—at any rate in our present state of knowledge—being more valuable. In any case the present death-rate of chloroform is estimated as about 1 in 4,000, whereas up to now that of stovain and novocain is appreciably much higher. In conclusion he urged that these drugs being new, and, so to speak, on their trial, they should avoid praising them too highly as absolutely safe, or condemning them too readily as too dangerous.

The PRESIDENT said that Mr. Canny Ryall brought about spinal analgesia in a patient of his for the operation of appendicectomy. She was under the influence of the anæsthesia in less than eight minutes from the commencement. He removed the appendix in a comparatively short time, and she was chatting the whole time, and seemed to take little or no notice of the operation itself. There were no bad symptoms afterwards, no vomiting or headache, and the patient made a natural recovery. With regard to his personal opinion, no doubt it took time to get used to new fashions. He preferred to get his patients under a general anæsthetic. Dr. Swanton went carefully into the condition of the pulse at various periods of the operation and of the anæsthesia, and he believed at one time it went as fast as 150 per minute. A question which arose was, was that caused by the anæsthetic, or by shock or nervous depression; or was it due to the operation itself?

Dr. GILES said, with reference to the subject of spinal analgesia, he thought all honour should be given to the pioneers of a method of treatment such as the present one, and Mr. Canny Ryall was to be congratulated in that he had picked up the subject for himself, and carried it so far towards a successful issue. The general mortality from general anæsthesia, such as ether anæsthesia, was something like 1 in 25,000; and although Dr. Hodgson attributed a good deal of serious shock after operations to general anæsthesia, he could not say that he altogether agreed. He thought that fatal shock after operations was generally due to operative and not anæsthetic conditions. But seeing the safety of the general practice of anæsthesia and the general satisfactoriness, some operators might be excused if they hesitated somewhat before adopting another plan. At present the mortality from spinal analgesia appeared to be a good deal higher. Whilst the new method had some advantages, it also had some disadvantages. But there was no doubt the only proper attitude to adopt was to preserve an absolutely open mind, and see how the results went; not discouraging the pioneers, but asking them, on the other hand, not to mind if their colleagues preferred to wait a while before using it.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

MEETING HELD THURSDAY, DECEMBER 13TH, 1906.

The President, Mr. PRIESTLY SMITH, F.R.C.S., in the Chair.

MR. E. TREACHER COLLINS described the macroscopic and microscopic appearance of an

ADHESION OF A PERSISTENT PUPILLARY MEMBRANE TO THE CORNEA

in the eye of a cat, and compared these with four other recorded cases of a similar nature. It was suggested that they might be divided into three classes with the following characteristics: (1) A cicatrix of a perforating ulcer of the cornea, with the pupillary membrane attached to the scar (Wintersteiner). (2) A cornea in all respects normal, except for a defect in the endothelium on its posterior surface at the seat of attachment of the pupillary membrane (Collins, Ballantyne). (3) A cornea in all respects normal, except for an absence of Descemet's membrane and its lining endothelium at the position where the substantia propria and pupillary membrane become blended (Von Hippel). The case, the subject of this communication, came under the third heading. In class 1 the cause of the adhesion was undoubtedly inflammatory in origin. In the cases belonging to the other two classes there was an absence of all signs of past or present inflammatory changes, and in some of the eyes there were other congenital malformations which could not be inflammatory in origin. The balance of evidence in them would seem to be strongly in favour of the abnormality being due to an arrest of development.

In class 2 the arrest occurring in the differentiation of the mesoblastic tissue, posterior to the hyaline layer of Descemet's membrane, into endothelium and pupillary membrane. In class 3 the arrest occurring in the formation of a partition of the hyaline layer and the differentiation of the mesoblastic tissue between the lens and surface epithelium into two parts.

Messrs. L. V. CARGILL and S. MAYOU described a case of

FLAT SARCOMA OF THE CHOROID.

The patient was a man, æt. 61, who was first seen in August, 1904, complaining of failure of sight of the left eye. At the outer side of the macula was a patch looking like an area of choroido-retinitis. The retina had an œdematous appearance, and at the lower border of this area were some dark choroidal pigment spots, with other spots less pigmented. The patch was not definitely elevated, but there was a scotoma corresponding to it; the vision was $^{6}/_{24}$. The right eye was normal.

In spite of warning, the patient did not show himself for a year, and then the retina was partially detached, with much pigment along the border of the detachment. Vision was $^{6}/_{18}$. The use of Leber's transilluminator rendered the diagnosis of tumour certain.

The patient was not again seen until March, 1906, when he had secondary glaucoma. Tension +2, and vision P.L.

The eye was removed, and a funnel-shaped detachment of the retina was present. In the outer half of the globe there was a flat, darkly pigmented growth. In the region of the ora serrata it was raised and tended to spread in a ring-like manner. The optic nerve and sclera were not involved. The growth was strictly limited to the choroid, and was composed of spindle cells with no alveolar arrangement, and a few large chromatophores. Anteriorly it showed well-marked signs of degeneration necrosis; there were also some small hæmorrhages.

Dr. CECIL SHAW (Belfast) read notes of a case of

PERFORATING WOUND OF THE EYEBALL,

with complete destruction of the iris and retention of vision. The patient was an engine-driver, æt. 37, who was removing the tyre of a bicycle, when the wrench which he had inserted under the edge of the tyre slipped and flew out, striking the right eye, and cutting the cornea from edge to edge a little below the centre. The anterior chamber was filled with blood, and when after some days this cleared off, it was seen that the iris had completely disappeared, leaving the lens in place, but evidently injured at its lower edge, from

which a few opacities spread through its lower third. These showed no tendency to increase. The wrench was a particularly sharp and rough-edged one, and probably caught the iris and tore it out. All signs of irritation passed off in about a month, but some floating opacities remained in the vitreous. The man was able to return to his work in six weeks with vision $^{6}/_{18}$ and $^{6}/_{12}$ partly in the injured eye.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

Meeting held December 7th, 1906.

Dr. Leonard Mark in the Chair.

Mr. Donald Armour read a paper on

Perforation in Typhoid Fever,

in which he stated that perforation was more common in men than in women, very rare in children, and the third week of the disease was the most frequent time. Out of 167 cases the perforation was situated in the ileum in 136, or 81.4 per cent.; in the large intestine in 20, or 12.9 per cent., in the vermiform appendix in 5, or less than 3 per cent. The symptoms on which most dependence could be placed were sudden acute pain in the abdomen, collapse, and an abrupt fall of temperature. Intestinal hæmorrhage and a steadily rising leucocytosis were danger signals. He dwelt on the great importance of early recognition of the symptoms, and the calling in of surgical aid. In suspected cases in which it was impossible to arrive at a diagnosis in other ways, a small exploratory incision under local anæsthesia should be made.

The use of opium was only justifiable after the diagnosis had been made. In operating two points should always be remembered. (1) That there may be more than one perforation present; (2) That it is necessary to examine the appendix before closing the abdomen.

Mr. McAdam Eccles agreed that an operation should be prepared for immediately the signs and symptoms of perforation were apparent, and alluded to the difficulty of diagnosing between perforating appendicitis, and perforations in enteric.

Mr. Paton thought that a Widal's reaction should always be taken as an aid to diagnosis.

Mr. F. G. Lloyd agreed that opium should be given after diagnosis so as to lessen shock, and to keep the patient in a better condition for the operation.

Dr. A. E. Russell also read a paper on the

Etiology of Uræmia.

The cerebral manifestations of uræmia were alone considered. The similarity between many of the symptoms of uræmia and those of conditions attended with increased intracranial tension was remarked upon. Indeed, uræmia had often been diagnosed erroneously as cerebral tumour. Conditions of increased intracranial tension were apt to be associated with an increase in the blood pressure. The meaning of this had been made clear by Harvey Cushing, who showed by experiments on animals that an increase of intracranial tension was associated with a gradual and corresponding rise in the peripheral blood pressure; within certain limits the blood pressure rose to a point above the intracranial tension. Without this compensatory rise in blood pressure the cerebral circulation would cease when the intracranial tension became equal to that of the blood pressure. Cushing had also shown that in cases of intracranial hæmorrhage associated with a high puels tension, the blood pressure fell to a most marked extent on trephining, and evacuating the blood. Similarly with cerebral tumour the general pressure symptoms were markedly relieved by operative measures designed to lower the intracranial tension; convulsions ceased, headache and vomiting were relieved, and optic neuritis subsided.

In uræmia a very similar group of symptoms was often to be seen, and inasmuch as the condition was then commonly associated with an increased blood pressure, it was permissible to enquire whether the explanation might not be the same, viz., that the intracranial tension was increased. That this is so was practically proved by the large number of cases which have been reported in which immediate and striking relief followed on lumbar puncture in uræmia, and it was to be noted that the relief was most marked when the cerebro-spinal fluid spurted out from the needle, *i.e.*, when the pressure within the spinal space was greatest. It was urged that in such cases lumbar puncture should be performed.

Mr. McAdam Eccles said that it was a physiological fact that the removal of cerebro-spinal fluid was followed by rapid resecretion of the liquid, and suggested the advisability of prolonged drainage in cases where simple puncture was ineffective.

Mr. Keetley, Mr. F. G. Lloyd and others took part in the discussion.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

Section of Medicine.

President—Joseph M. Redmond, M.D., P.R.C.P.I.
Sectional Secretary—F. C. Purser, M.D., F.R.C.P.I.

Meeting held Friday, December 7th, 1906.

The President in the Chair.

OUR DEBT TO IRELAND IN THE STUDY OF THE CIRCULATION.

Dr. George A. Gibson (Edinburgh) read a paper on the above subject. He said that from his earliest days the heroes of medicine in Ireland had always been the objects of his worship. The first of the medical works produced by Ireland which had come into his possession was a copy of the first edition of Graves' immortal lectures; and he believed that for felicity of diction, breadth of view, and originality no other clinical lectures could be compared to them. Another Irish work of similar lucidity, greatness of view, and originality was "Stokes on the Heart." It was, he averred, the greatest book on the heart that had ever been published, and still stood absolutely without parallel. In that book Stokes coined the term "embryocardia" fifty years before it passed into currency, and he did more for the study of aneurism than any of his predecessors. Long before Oertel, Stokes had enunciated the advantages of exercise in the treatment of heart disease, and other methods of treatment which had slowly filtered into the minds of the medical profession since. Amongst numerous books and papers, all of great value, the speaker instanced the papers by Sir Dominick Corrigan on aortic disease as being epoch-making, little having since been added to the information contained in them. Amongst isolated papers upon cardiac disease perhaps the most valuable that had ever been published was one by the celebrated Adams, which appeared in the fourth volume of the "Dublin Hospital Reports." Many of his friends had been in the habit of attributing to John Hayden the information that when pericarditis followed on acute rheumatism the cause of the exudation, whether it was fibrinous or liquid, was that the heart was always in movement; but that had been expounded by Graves long before John Hayden. In looking through old files he had been struck with the fact that little had been written on angina pectoris, and he was inclined to hope that Ireland escaped that fell malady more than the sister islands. In other respects, Graves and Stokes were precursors of much now known. Somewhere in the thirties there was noticed a case of paralysis of the leg due to arterial obstruction—a forerunner of the views now enunciated as intermittent claudication. A host of Continental observers had studied the question of the causes of murmurs, but the results of their observations were practically all embraced in Corrigan's comprehensive work. Adams, in 1827, anticipated a good deal of subsequent work as regards the effects of mitral

obstruction on the chambers of the heart, and Hayden and others during the third quarter of the last century did almost all the work of importance on the subject of cardiac murmurs. Even so far back as 1772, M'Bride's "Practice of Physic" showed that slowness of the pulse in fatty disease was then known. Bellingham undoubtedly conceived the modern treatment of aneurism by dietetic and physical means. In his (the speaker's) own experiments he had proved to his satisfaction, and the satisfaction of others, the accuracy of conclusions which had been arrived at by Hunter, Adams and Stokes; and his observations had led him to expect that some time or other they should be able to hear a murmur of regurgitation at the pulmonary orifice like what was found in regard to the tricuspid orifice. The murmur had since been heard. In 1835 the Dublin Committee of the British Association stated that the auricles could produce sound on contraction. The observation was allowed to escape notice, and the subject did not emerge until about 1879 or 1880, when a distinguished graduate of Trinity College and he had studied a case of cleft sternum, and were always able to hear the movement of the auricles. Stokes had heard the same sounds. Other observers had taken up the subject, and it had occurred simultaneously to Professor Finny, the President of the Royal Academy of Medicine in Ireland, and to Professor Ritchie, his own clinical tutor, that the X-rays might be of use in the study of heart conditions. With the aid of lantern slides Dr. Gibson exhibited a series of tracings from his own studies in heart block. The slides showed the features during life and the pathological condition after death, and might, he held, be taken as proof positive that heart block was proved by the auricular sounds heard in the intervals between the apex pulsations.

The thanks of the Academy were conveyed to Dr. Gibson by the chairman, who was followed by Prossor Finny, Professor Little, Sir John Moore, and Professor W. H. Thompson.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

THE Winter Clinical Meeting of this society was held on December 19th, when a number of interesting cases was brought forward by members. Among the principal exhibits were pathological specimens by Prof. Annandale, Dr. Bruce, and Messrs. Cotterill and Cathcart.

Dr. GIBSON gave a demonstration of the use of Erlanger's sphygmanometer.

Dr. BYROM BRAMWELL showed cases of thrombosis of the pons and loss of the stereognostic sense from head injury.

Dr. BRUCE, cases of hæmorrhage into the optic thalamus, anterior poliomyelitis, primary myopathy, and disseminated sclerosis.

Dr. PHILIP, cases of chylous ascitis, extreme dyspnœa treated with Béraneck's serum, tuberculous glands healed with tuberculin.

Dr. EDWIN BRAMWELL, case of multiple syphilitic lesions of the nervous system and congenital paralysis of the face and ocular muscles.

A number of interesting surgical cases were also exhibited, among which a man, æt. 45, after incision and drainage of a mesenteric cyst containing brownish semi-fluid material, and a patient after incision, packing, and drainage of an enormous bleeding cavity in the right hypochondrium, believed to be due to an acute hæmorrhagic pancreatitis, shown by Mr. Alexis Thomson; a patient after removal of the Gasserian ganglion, by Mr. Cathcart; and cases of talipes equino-varus, treated by Lorenz's method, and of surgical tuberculosis treated by Tuberculin R. by Mr. Peel Ritchie, may be mentioned.

AN outbreak of scarlet fever is reported to have occurred at St. Andrew's. The original case has been traced to a dairy outside the burgh boundaries.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

GERMANY.

Berlin, Dec. 23rd, 1906.

At the Society for Innere Medizin Hr. A. Fraenkel showed

PREPARATIONS OF INFANTILE PARALYSIS

and described the pathological anatomy.

Hr. Kraus asked if lumbar puncture had been performed, to which Hr. Fraenkel replied that it had for purposes of relief. From the clinical aspects of the case an infective disease might be assumed, as spinal paralysis sometimes occurred in epidemics.

Hr. Heubner had observed and performed an autopsy on a similar case of infantile paralysis twelve years ago. In regard to pathology it was remarkable how quickly the ganglionic cells were destroyed. This was in evidence in the preparations shown. Not long ago he performed lumbar puncture in a case, but did not find the meningococcus in the cerebrospinal fluid. He had also recently seen a case of cerebrospinal meningitis; possibly there was a connection between the two.

At the Hufeland Society Hr. Korte gave an address on

THE OPERATIVE TREATMENT OF GASTRIC ULCER.

It was uncertain how frequently hæmorrhage took place in gastric ulcer. Serbe placed the frequency at 1 per cent., Gerhardt and the English at from 13 to 18 per cent. In Berlin Brentano in 120,000 patients had 75 perforations amongst them, 46 women and 29 men.

The prognosis of perforation under internal treatment was bad; fatal peritonitis generally followed, recovery rarely. It was to be observed that in nervous persons a pseudo-perforation took place. The statement that 1 to 5 per cent. of recoveries took place was arbitrary. He had never seen a case. The prognosis was more favourable when perforation took place into adhesion and a subphrenic abscess formed. Mitsuliez was the first to operate in such cases. His first patient died. The first successful case in Germany was Heusler's. As regards recovered cases, England had at first the preponderance; in Germany the results were steadily improving. His own operation cases formed two series from 1890 to 1900 with 10 cases. Of these only one recovered, and even in this it was doubtful whether the perforation did not take place into adhesions. The second series gave better results. In these (19) the perforation was discovered and closed in 17; in two cases this was not done, as the diagnosis was incorrect. Of the 17 cases, 13 recovered and 4 died. The better results were due to earlier operation and not to improved technique; early operation was the most important of all the factors.

Twelve patients had stated that they had been treated before for stomach troubles. Two had had hæmorrage; 3 had had "weight" on the stomach; 4 declared that they had never suffered from any stomach affection. In four gastro-enterostomy had already been performed for abscess; in two cases the perforation took place at the juncture between the stomach and the intestine. Only two patients attributed the perforation to injury. Fulness of the stomach could not be the exciting factor of perforation. It happened in the morning after breakfast, which was not a copious meal. The patients collapsed at work; two after mid-day; but it might occur also in the night. The symptoms, especially at the commencement, were typical, so that diagnosis was easy. There was violent pain from irritation of the serosa of the peritoneum by the acid gastric juice. The most important sign was tension of the abdominal muscles. For the first few hours the abdominal walls were not distended, but board-like with tension, especially in the region of the rupture. After describing the well-

known symptoms, the speaker said that errors might be made. It was very unfortunate if the symptoms were attributed to the appendix, and this was cut down upon. The acid smell of the abdomen when opened showed the way to the correct spot. He had lost two cases from this error. The patients operated on within nine hours all recovered; all those operated on after 22 hours died.

The initial collapse was not a contra-indication of operation. In the early stages patients were given camphor, caffeine and saline infusions. In this stage an injection of morphia was useful. As regarded operation, the trinity of rules was: speedy operation, rapid finding of the perforation, cleansing of the abdomen and closure. A long incision was required.

The majority of ulcers were on the anterior wall, mostly near the pylorus; next on the lesser curvature and near the cardia. The opening was generally found on raising the left lobe of the liver. The opening was closed by simple suture; in many cases the edges had to be pared. A little bunch of omentum was stretched over the sutured parts. If the ulcer was near the pylorus, or if this was contracted, it was generally better to do a gastro-enterostomy. This was done in nine cases, two of which died.

A bacteriological cleansing of the abdominal cavity was impossible. It was best to wash out with physiological solution. The intestine might prolapse, and have to be punctured and emptied. The last remains of fluid would be absorbed.

In the after treatment analytics were given freely. Collapse generally took place in 10 to 12 hours. Patients were warmly wrapped up after operation, were given subcutaneous injection of camphor, caffeine and saline injections. A tablespoonful of tea every hour, etc. From the second week broths, etc., and meat from the third week. If the healing of the ulcer had not progressed the stomach was washed out with a weak solution of nitrate of silver, 1 : 2,000.

With rupture into adhesion patients did not die so readily. After a stormy commencement the symptoms quietened down; then a complex febrile condition supervened that lasted a long time, after which a subphrenic abscess formed. Of 12 patients with subphrenic abscess starting from the stomach, only six recovered.

AUSTRIA.

Vienna, Dec. 23rd, 1906.

Peripheral Facial Paralysis.

At the Gesellschaft für Innere Medizin Golreich exhibited a child, five months old, with left-sided facial paralysis, the result of malformation of the left ear. Congenital facial paralysis of this nature was a rare occurrence, and worthy of the society's consideration. The cause in this case was evident from the want of development in the bony structure of the ear, thus injuring the peripheral nerve in its course outwards.

Schüller related a similar case with this combination of otic malformation of the left ear and congenital paresis of the left facial nerve. He used electric stimuli to the nerve at once, and to-day the paresis is quite gone. There was no doubt as to the peripheral nature of the disease and the cause of the affection, which we must accept as mechanical.

Neurath gave a short history of an allied case of multiple malformations with neurotic symptoms, but which he diagnosed from the pathology as congenital "Kernaplasia."

Frey said that all otiatric literature recognised the connection of this form of paralysis in conjunction with this malformation of the parietal bones, middle and outer ear. The first defect was in the parietal bones, the second stage was the inhibition of the development of the facial, and the third change lay in the asymmetry of the skeleton of the face.

Swoboda differed from Frey in accepting paralysis as a constant factor in malformations of the ear and parietal bones, as he had seen cases with all these defects and no paralysis or paresis present. On the other hand, he had seen perfectly well-formed children with congenital facial paralysis. He could not believe that the atrophy of the facial region was a cause, but rather thought it was a result.

Aortic Aneurysm.

Weinberger demonstrated by means of the Röntgen rays a case of Aortic Aneurysm situated on the upper portion of the curve. It was firmly pressed against the left recurrent nerve, trachea and upper portion of the bronchus, causing atelectasis of the lower portion of the left lung. The heart and contents of the mediastinum were pressed far to the left of the thorax.

Desquamation of Nails.

Schick showed a twelve-year lad with the scarlet fever line well marked on all his finger-nails. These lines were observed about fourth week of the disease as crescentic lines passing forward to be shed like the epithelium of the skin, which he considered analogous.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

Medical Officer for Edinburgh School Board.—The Edinburgh School Board has at length taken a step in the right direction in deciding to appoint a medical officer. It is impossible, however, not to sympathise to some extent with Councillor Lashman's objection to the report recommending this step, for the first regulation (and there are fifteen others) reads as follows: "He shall advise the Board as to new sites, plans of new schools, and also, when required, as to school apparatus; he shall exercise a general supervision over the ventilation, heating, lighting, and cleanliness of the schools; he shall periodically inspect all school lavatories and other sanitary installations, and he shall report immediately to the head-master, and, if necessary, to the superintendent of works, any insanitary conditions discovered." Councillor Lashman said that if they got a man able to do all implied in that regulation they were going to get a wonderful man, and went on to say that if they expected so much they should pay a salary of £4,000 rather than the £400 offered. It is to be supposed, however, that what is really demanded is that the new official shall guide the School Board in sanitary and other matters with an expert medical opinion; his duties should be critical rather than constructive, except in his own particular line, and probably the burden looks greater in the regulation than it would be in reality. With regard to the salary, we unhesitatingly say it is inadequate, as the medical officer appointed is required to give up his whole time to the work. This was apparently felt to some extent, for in his concluding remarks the Chairman of the Board said that, though they believed they could get a very good man for £400, it would be for the Board to give the matter further consideration if the attraction was not sufficient to secure the kind of man they wanted.

LETTERS TO THE EDITOR.

"OBJECTION TO DOCTORS."

To the Editor of The Medical Press and Circular.

Sir,—Together with the usual number of your admirable journal of to-day, December 12th, there is laid upon my table the *Times* and the mid-weekly issue of the leading local county paper. In your journal I notice an editorial paragraph with the heading of this letter, pointing out that patients will often bear for years excruciating suffering rather than see a doctor. There exists widespread distrust and dislike of the profession. Every practitioner must be aware of this; but perhaps everyone does not trouble to examine into

the causes. These causes are sufficiently well indicated in my two lay papers. In the *Times* appears a report of an anti-vaccination meeting. Mr. Lupton, M.P., enlarges upon the theme that vaccination is a "piece of eighteenth century quackery, a dangerous and useless practice." Lieut.-General Phelps discourses on the "Legends and fairy tales told by small-pox hospital authorities. The patients in those institutions die, not from small-pox, but from the treatment." Then there are the anti-vivisectionists, with three or four societies amply provided with funds. These fanatics hold up the most respected, distinguished, and self-sacrificing of medical scientists as fiends in human shape, delighting in the infliction of horrible torments upon animals, in spite of the demonstrated futility of their labours; and they suggest that the practices and teachings of these scientific men destroy the humane feelings of medical students—practitioners in process of manufacture. I send a sample from the county paper before me. This advertisement, enormous in size, and with huge capital head-lines, must cost some pounds weekly. It is only one of many of the same class appearing in all country papers. The vast outlay in advertisements is a measure of the extent to which the public is plundered. The advertisement teaches that the profession is of the types which the fanatics above named describe. It proclaims that disease is very simple, but it is the doctors that usually kill people; that the quacks can cure all maladies—the advertisement names scores of organic diseases—including consumption, paralysis, epilepsy, and Bright's disease; whilst cancer and rupture are cured without the operations which surgeons advise, with the result that the fools who submit to them are often ruined for life. The profession looks on at all this with perfect apathy, and the simple public are now the helpless victims of the most extensive of all the cruel systems of fraud that are at the present day carried on by the parasites of modern society.

I am, Sir, yours faithfully,

Reigate, Surrey, December 12th, 1906. S.

THE MOUTH AS A FOCUS OF INFECTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I am much obliged to "Hospital Dentist" for the kindly manner in which he refers to my paper. The space at my disposal was limited, or I should certainly have dwelt at greater length on the treatment of Pyorrhœa alveolaris, a subject which has long interested me in its bacteriological aspects. I should be the last to ignore the value of the services of our dental colleagues, to whom we owe so much. May I in return for the courtesy of "Hospital Dentist," venture to call his attention to an excellent lecture recently published on "Present Views on Diseases of the Joints," by Professor Howard Marsh, who refers to the frequency with which joint affections follow septic conditions of the mouth. He points out that the part played by the tonsils and the lymphatic tissues of the pharynx in harbouring agents by which the joints may be infected has only recently been fully appreciated, and gives details of two cases in which after carious teeth were cut down level with the gum and a new crown was applied, the patients became subject to what was regarded as acute osteo-arthritis involving several of the large joints, and those also of the hands. In both these, after operation by a dental surgeon, the joint affection was arrested.' I regret that I have not yet had an opportunity of seeing Mr. Sewill's "Manual of Dental Surgery," referred to, which is evidently regarded as authoritative.

I am, sir, yours truly,

FREDERICK NORMAN, F.R.C.S.

THE SYSTEMATIC LECTURE NUISANCE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I am pleased to see that someone (Sir Thomas Myles) has at last had the courage to attack that belated institution, the systematic lecture. As a student I always felt that attendance at these archaic functions was an egregious waste of time. I can conscientiously affirm that I learned very little from such lectures; the lecturer discoursed either of things I knew, in which case it was a labour of supererogation, or he wandered into realms not yet explored by me, in which case I was soon "off my feet," and failed to derive any benefit.

Abroad—in France at any rate—attendance at lectures is not compulsory, although it is thought good policy to make a point of occupying a foremost place for a few days before the examinations, in order that one's features might not be altogether strange to the lecturer, *qua* examiner.

We do not *read* medical books; we con them over and over again until the facts have acquired a footing in the memory. How many times such facts have to be recapitulated every student knows. What good, then, can it be to pass highly technical subjects rapidly in review before the bewildered minds of raw students.

The resistance to the abolition of the lecture system will come from "vested interests," and we may be sure that it will die hard. It had a *raison d'être* when books were scarce and costly, and when scientific writers had not yet learned how to classify and enforce their facts. One need only turn back to the text books of some thirty years ago to appreciate what I mean by that. Now, however, all is changed, and systematic "teaching" is an anachronism. No, theoretical, or rather systematic, learning is best obtained from books, especially now that they are so graphically illustrated, and the rest must be acquired in the laboratory and at the bedside. After all, it is only a question of time, though I do not look to the General Medical Council to assist any movement in this direction.

I am, Sir, yours faithfully,

ICONOCLAST.

STAGHUNTING AND VIVISECTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I have read your comments on a recent Surrey Staghunt, and there is no getting away from the sting of them. Though I abominate the practice of vivisection, I cannot see how I could logically denounce it, if I did not strongly reprobate the cruelties carried on by sportsmen.

The very name "*sportsman*" is condemnatory. How can a person ever be justified in torturing or killing creatures for simple amusement? The thing is absolutely immoral; and if sporting people would only reflect a little they would surely see it in this light. If a butcher boy told us he found delight in the slaughter of cattle, we should warn him against developing into a criminal. Such being the case, why should it be deemed laudable conduct when the upper classes mow down hand-reared pheasants, leaving many wounded to crawl away and die a lingering death, or turn out park deer and chase them time after time to the point of exhaustion, or hunt to death foxes, otters, hares, and the wild stags of Exmoor? These creatures could all be killed with less pain than they are by the means employed.

How can we call this country a Christian land when such sports go on? Why is not the pulpit made an instrument for reforming these sporting cruelties out of existence? It is a scandalous thing that some of the clergy are their patrons. The democracy must take the matter in hand and generate more worthy ideas.

I am, sir, yours truly,

Wokingham, Dec. 21st. (REV.) J. STRATTON.

VEGETARIANISM AND ALCOHOL.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In one of his recent works Maeterlinck advances as a argument in favour of a vegetarian diet that a taste for alcohol is created by indulgence in meat, and that when this is abandoned the alcohol habit follows suit. I was struck by the remark, and have since taken advantage of my opportunities to see whether there was any ground for the assertion. I began by trying the experiment of a vegetable meal, and I certainly felt disinclined to take either wine or beer with it. Inasmuch, however, as I hanker

after the fleshpots, I transferred my attention to sundry patients who appeared to have much to gain by the adoption of a non-meat dietary. I imposed no restriction in regard to alcohol in any form, leaving them free to follow their inclinations. Without a single exception I found that so long as they persevered with the regimen I had laid down they ceased to derive any satisfaction from strong drinks; indeed, two of them deliberately returned to their ordinary food because, forsooth, they said they "could no longer either drink or smoke with any degree of satisfaction." I do not remember any chronic inebriates among my acquaintances, professional or social, and the only one I ventured to approach on the subject declined to have anything to do with my suggestion.

I feel convinced that there is a co-relationship between meat-eating and alcohol drinking, and if this be so it is a point worth bearing in mind in the organisation of the homes for inebriates now in course of construction.

I am, sir, yours truly,

ALFRED S. GUBB, M.D.

Mustapha Superieur, Algiers.
Dec., 1906.

OBITUARY.

ALFRED SHEEN, M.D., D.P.H., M.R.C.S.

By the death of Dr. Alfred Sheen on December 16th, Cardiff lost one of its most respected medical men. Dr. Alfred Sheen had a varied career. Born in Leicester, he was educated at Hurstpierpoint, and in 1855 went to Madras to take up a Civil Service appointment. The work, however, was not congenial, and Mr. Sheen entered the Madras Medical College, where he was a student until 1860, taking a number of prizes. Returning to England, he completed his medical studies at Guy's Hospital, and qualified in 1862 as M.D. (St. Andrews) and M.R.C.S. (Eng.). He came to Cardiff in 1864 as house surgeon at the infirmary, and held that appointment until 1866, when he went into practice. Dr. Sheen was appointed hon. surgeon to the Cardiff Infirmary in 1871, and resigned that position after twenty years' service. In 1900 he was appointed consulting surgeon. Dr. Sheen was also visiting medical officer at the Cardiff Workhouse for thirty-six years, and wrote a book entitled, "The Workhouse and Its Medical Officer," which was accepted by Poor-Law Medical officers as a standard work. Dr. Alfred Sheen was one of the founders of district nursing in Cardiff, and was president and hon. treasurer of the Jubilee Nurses' Institute, and also acted as hon. medical officer. He was a member of the council of the University College of South Wales and Monmouthshire for many years, and took great interest in the medical school, giving a scholarship which is awarded annually.

WALTER J. SYKES, M.D., D.P.H., F.I.C.

We regret to record the death of Dr. Walter John Sykes, of East Grinstead, who passed away in his sleep on December 16th. Dr. Sykes was an M.D. (Edin.) a member of the Council of the Public Analysts' Society and editor of the *Analyst*, and late Medical Officer of Health and Public Analyst for Portsmouth Borough. He was also the author of "Principles and Practice of Brewing." He took a great interest in music, and was conductor of the East Grinstead Orchestral Society. He was 64 years of age, and had resided at East Grinstead for nearly ten years.

JOSEPH HARRISON, L.R.C.P., L.R.C.S.Edin., L.S.A.

The death of Dr. Joseph Harrison, which took place on December 18th, in his sixty-fourth year, removes from Bradford a well-known personality. Dr. Harrison who lived practically all his life in Bradford, was originally an operative in the wool trade. He worked with great diligence at the Bradford Mechanics' Institute, where he carried off a number of diplomas in the Society of Arts examinations. Afterwards he became a teacher of science, and his services were in considerable request in many parts of the West Riding. Becoming a student at the Leeds School of Medicine, he was admitted a licentiate of the Royal College of Physicians of Edinburgh in 1879, and a licentiate of the Royal College of Surgeons of Edinburgh in 1883, taking also a medal in practical chemistry. Since then he followed the medical profession.

MEDICAL NEWS.

Metropolitan Asylums Board.

At an ordinary meeting of the managers of the Metropolitan Asylum District, held at the office of the Board, on the Embankment, on Saturday week, Mr. A. C. Scovell presiding, Mr. Ecroyd moved:—"That the General Purposes Committee be instructed to consider and report as to the advisability of discontinuing the river ambulance service and arranging for the transport of future small-pox patients by road." He said the river ambulance steamboats used for the conveyance of small-pox patients were obsolete and practically useless, while their upkeep cost £7,000 a year. Mr. J. T. Helby seconded the motion on the ground that an inquiry might be advantageous. Sir Robert Hensley said the reference was absolutely futile and premature. During the small-pox epidemic of 1901-2 the number of patients conveyed to small-pox institutions daily varied between 50 and 100, and this mode of conveyance was, in his opinion, preferable to conveyance by motor-cars, as had been suggested. Professor Smith said the river ambulance service was of a most admirable kind. It represented years of development and of thought, and any one of the ambulance steamers to-day was about as perfect as any of the hospital wards which the Board had under its control. He thought that nothing would justify an alteration of the system. After further discussion the motion was adopted. The returns of infectious cases showed that during the fortnight ended last Thursday week 1,159 patients had been admitted to the Board's fever hospitals, 64 had died in those institutions, and 1,268 had been discharged recovered; the total number remaining under treatment being 5,270, as compared with 5,443 a fortnight previously. Of that number, 4,051 were sufferers from scarlet fever, 1,051 from diphtheria, and 168 from enteric fever. There were no small-pox patients under treatment.

A Bogus Doctor.

On December 4th, George Gill, aged 50, was charged at Burnley with falsely pretending to be a surgeon. Evidence was given that in March last the accused carried on practice as a doctor in Abel Street. He had on his window "Dr. G. Gill, Provident Medical Dispenser." A Mrs. Butterworth consulted him about her child. The following month he again attended the child, and said it was suffering from the same complaint as before. He gave it some medicine. The child died in a day or two, and accused being unable to give a certificate an inquest was held. Gill was summoned to this, but decamped, and was only apprehended a week ago. Gill said he had been in the army and had had some amount of medical training. He was fined £10 and costs or two months.

Royal College of Surgeons of Edinburgh.—The Fellowship.

The following gentlemen, having passed the requisite examinations, were at a meeting of the College held on 17th inst., admitted ordinary Fellows:—W. C. Allardice, M.D., J. Brydon, L.R.C.S.Eng., C. V. Cornish, M.R.C.S.Eng., H. S. Davidson, M.B., Ch.B., D. Dickie, M.B., Ch.B.; H. Norman Goode, M.B., M.R.C.S.Eng., H. W. Illius, M.R.C.S.Eng., R. W. Johnstone, M.D., T. W. Kirby, M.D., M.R.C.S.Eng., J. R. Lee, M.B., T. E. Lloyd, M.R.C.S.Eng., J. P. Morton, M.B., L.R.C.P.Eng., T. Y. Simpson, M.D., M.R.C.S.Eng., H. Stuart, M.D., M.R.C.S.Eng., and F. W. Sydenham, M.D.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT PATHOLOGICAL LITERATURE.

Carcinoma in Mice.—Clowes (*British Medical Journal*, December 1, 1906) publishes a comprehensive account of the investigations into cancer in mice, conducted in the New York State Laboratory. (1) He finds that the primary tumour is only transplanted with difficulty. After the first generation the yield of tumours gradually increases until a maximum virulence is obtained, which subsequently remains fairly constant. Thus in the case of one tumour the first transplantation only gave positive results in 5 mice out of 28 (17 per cent.), with a long average period (over 74 days) between inoculation and the fatal result, whereas at the fifteenth generation 91 per cent. of the inoculations gave results, with a period of 25 days. In the case of a less virulent tumour, inoculation failed altogether in the early generations, unless the material were incubated at a temperature between 38.5 degrees C. and 41 degrees for half an hour before injection. At the seventh generation, 57 per cent. of inoculations with the incubated material were positive, and 20 per cent. with the normal. The material for inoculation was in all cases obtained by grinding up a tumour with salt solution in a mortar, and removing the shreds of connective tissue. (2) Increase of virulence is associated with increased rate of growth. This has been shown by the parallelism observed between positive results of inoculation and shortening of the period before death. (3) Incubation of material before inoculation increases its virulence until a maximum has been reached. (4) The resistance of tumour cells to disinfectants is high. It was found possible to destroy the bacteria in badly infected tumours without seriously affecting their virulence. (5) Tumours with a high potassium and micro-proteid content are more virulent than those with a low potassium and high calcium content. (6) Immunity to cancer occurs in mice. Mice which have recovered spontaneously from cancer cannot be affected by tumours of an equal degree of virulence, and they exhibit a high resistance to tumours of greater virulence. Moreover, the serum from mice which have recovered exerts a definite action when injected into tumours in other mice. Inoculation, however, with tumour material treated by a high temperature or by chemicals in such a way as to render development impossible, entirely fails to confer immunity. Inoculation with micro-proteid extracts of tumours is also without effect. Clowes also discusses with reference to Ehrlich the possibility of tumour formation being due to the stimulus given to certain cells by the presence of a toxin, and he inclines to the view that such is the case, and that the toxin is the result of the activity of a parasite which has infected the cell. R.

Examination of the Blood.—Gulland (*Scottish Medical and Surgical Journal*, December, 1906) discusses the methods of clinical examination of the blood available for general practitioners, and illustrates their value by reference to points of practical diagnosis. The paper does not profess to contain anything new, but it is both comprehensive and terse. (1) Estimation of hæmoglobin can be conveniently made by the Tallqoist hook, or, if more accurate results are required, by Haldane's instrument. Gulland illustrates the need for a hæmoglobin estimation in cases of supposed chlorosis by recounting the history of a patient with normal amount of hæmoglobin, who, by reason of poor circulation, and thick skin, looked pale, and was treated unsuccessfully by hæmatinics for months. Again, the determination of the colour index is of great importance in distinguishing the various forms of anæmia. (2) Enumeration of the red corpuscles is best done by Thoma's instrument. (3) For counting the leucocytes Thoma's apparatus is also recommended, using as diluting fluid a 1 per cent. watery solution of acetic acid, coloured light green by methyl green. (4) Films are most easily stained by Jenner's stain, which Gulland thinks superior to any of its modifications. He is right in emphasising the fact that almost the whole art of making films lies in proper cleansing of the cover-glass. "If the cover-glasses are clean, almost anyone can make good films. If they are not clean, no one can do so. (5) The presence of glycogen granules in polymorphonuclear leucocytes is detected by dropping the film on a drop of dilute iodine (1 in 100) solution. Gulland regards a positive reaction as of great importance, signifying the presence of a toxæmia. The more marked the reaction, the more severe the toxæmia. It is commonly due to infection by the pneumococcus, the streptococcus, the staphylococcus, or the bacillus coli, but may be due to other infections, or to such conditions as uræmia and morphia poisoning. Gulland illustrates the advantages of careful blood examinations by showing their bearing on the diagnosis of such diseases as phthisis, pneumonia, typhoid, appendicitis, and puerperal sepsis. R.

Gastric Erosions.—Miller (*British Medical Journal*, December 1, 1906) publishes an account of a hitherto undescribed condition said to account for the occasional hæmorrhages into the stomachs of dyspeptic patients. One of the changes occurring in gastritis is inflammation of the lymphoid follicles. They disintegrate and soften, and eventually burst, leaving a bare spot of the basement membrane. This undergoes gastric digestion, and the underlying vessels, having first formed small aneurisms, are likewise eroded, hæmorrhage resulting. The less healthy the mucous membrane, the more likely is the erosion to become extensive, since in the case of a healthy tissue repair is rapid. Miller accompanies his paper by illustrative photographs, showing various stages of the process he describes. R.

The Action of Röntgen Rays on Spermatozoa.—Attention has frequently been drawn of late years to the action of the X-rays on the reproductive organs, and particularly on spermatozoa. Bardeen (*British Medical Journal*, December 15th, 1906) publishes a brief note regarding the effect of X-rays on the spermatozoa of toads. He finds (1) that their fertilising power is lessened by exposure to the rays; (2) ova fertilised by such spermatozoa may die early or may develop into tadpoles, which, however, always show some abnormality; (3) the nervous and vascular systems are chiefly affected, but all the organs are more or less abnormal; (4) the abnormality may show a tendency to be unilateral. R.

The Evidence for Opsonins.—The doctrine of opsonins has up to the present rested almost entirely on the evidence adduced by English and American experimenters. On the Continent, both in France and Germany, Wright's views have so far failed to gain general support. Thus, Löhlein, of Leipsig, issues from Metchnikoff's laboratory, and presumably with his assent, a depreciatory criticism of the teachings of Wright, Douglas, Hektoen, Bulloch, and others, on the subject of phagocytosis *in vitro* (*Annales de l'Institut Pasteur*, November 25th, 1906). He has made experiments with the anthrax bacillus, the streptococcus, the bacillus coli, and the cholera vibrio, and he comes to the following conclusions:—(1) Phagocytosis *in vitro* only depends in a restricted number of cases on the presence of favouring substances (opsonins) in the free state. If it be true that phagocytic

action only takes place with the help of these bodies, then it must be admitted that they may be provided by the leucocytes themselves. (2) The normal serum of guinea-pigs contains bodies which by their action on certain pathogenic organisms prepare them, in certain cases especially, for phagocytosis. (3) These bodies are active at a temperature of 0 degree C., but are destroyed by a temperature of 55 degrees C. They have a constitution resembling that of agglutinins in that they consist of two groups. They are to be distinguished from bacteriolysins, from bacteriolytic sensibilisatrices, and from complements, but it is not at present possible to distinguish them from the agglutinins of normal serum. (4) The introduction of the term "opsonins" is unjustified, for these bodies play the part ascribed by Metchnikoff to "fixateurs."

R.

Spirochætes in the Lung.—Castellani and others have reported the discovery of spirochætes in the hæmorrhage of hæmoptysis, no other organism being discovered to account for any lesion. Branch (*British Medical Journal*, December 1, 1906) reports a case of phthisis with hæmoptysis in which spirochætes in large numbers were observed. Two distinct types were seen: (1) a stout, strongly stained organism, with regular curves, probably the *spirochæte refringens;* (2) a more delicate form, with closer waves, nearly resembling the *s. pallida*, but staining easily with ordinary aniline stains. The sputum was remarkably tenacious, and Branca has observed that ulcers, where *s. refringens* was present, showed a peculiarly viscid secretion; he suggests that the presence of the spirochæte may have to do with this viscidity in both instances. Although not regarding either of the forms observed as *s. pallida*, he notes that the patient had signs of old syphilis.

R.

The Histological Structure of Koplik's Spots.—Hlava (Casopis Pekaru Ceskych, 1906, p. 773) has excised the spots from the inside of the cheek in five cases of measles, and has examined them histologically. There existed in the neighbourhood of each a local hyperæmia and leucocytal infiltration, and in addition there was extensive keratinisation of the epithelium, with excessive desquamation. In the centre of each spot the basal epithelium was necrosed and liquefied, and in some cases there was an underlying small collection of pus, which was closely confined by the hardening of the surface cells. The keratinisation of the mouth epithelium is on a par with the changes that occur in the skin in measles, the only exception being that the process extends further from its centre, and is more often associated with vesico-pustular formation. Koplik's spots are, in short, the exanthem of measles occurring in the mucous membrane of the mouth, and becoming pustular. M.

Phlegmonous Inflammation of the Stomach and Œsophagus.—A case of this very rare condition is recorded (*Deutsch. Archiv. für Klin. Med.*, Bd. 87, H. 5 and 6). The patient, æt. 21, without apparent cause, began suddenly to suffer from severe pain in the neck and from dysphagia. The pain gradually extended down into the chest, swallowing became impossible, the larynx and pharynx were found to be enormously swollen, and death took place in seven days from general collapse. The necropsy showed an extensive purulent inflammation of the whole œsophageal and gastric wall, chiefly localised in the submucous coat. The superficial epithelium was intact, but purulent extensions were found here and there throughout the mediastinal tissue. The cause remained unrevealed, but it was suspected that the inflammation originated in the throat, perhaps as a result of some slight injury by a foreign body. From there it rapidly spread, producing the inflammation as described. M.

Pseudo-Chylous Ascites.—Zyptein reports two cases of this condition (*Weiner Klin. Woch.*, 1906, No. 34). After a study of the literature and as a result of his own investigations, he concludes that as yet no definite opinion can be expressed as to the nature of the substance which produces the characteristic appearance of these effusions. He conjectures that it is caused by certain chemical substances which are not present in ordinary serous effusions, and which have not yet been isolated; but it is possible to imagine that the qualitative chemical grouping of pseudo-chylous effusions is identical with that of simple ones, and that the only real change consists in the presence of an unusual quantity of some one ingredient, for example, lecithin, nucleo-albumin, or mucin. In the cases described by the present writer it was noticed that the intensity of the milky opalescence always decreased when the quantity of albumin present increased. M.

Digestion of Fat in the Stomach.—That a certain amount of fat is split up in the stomach has now been definitely established, but it is still a matter of doubt as to whether the splitting up is due to a ferment actually secreted in the stomach, or to a regurgitation of pancreatic juice from the duodenum. Heinsheimer has endeavoured (*Arbeit. aus dem path. institut zu Berlin*) to solve this problem by experiments on dogs. He has obtained gastric juice direct from the stomach by means of a gastric fistula, and also from isolated stomach pouches. Both products broke up fat to a slight extent, the digestion being most complete when the reaction was acid. From this it is concluded that the stomach itself must secrete a lipolytic ferment, as no communication with the intestine existed in the cases where a stomach pouch was made. It was, moreover, noted that the pancreatic ferment can only act in a neutral or alkaline medium. The gastric ferment was very scanty, and disappeared altogether after a few days. It is present also to a slight extent in human gastric juice, and as obtained from it will act in a neutral, acid, or faintly alkaline medium. M.

Phlegmonous Gastritis.—To the eighty cases of this condition that have been reported in the literature, Schnarwylen now adds and describes three. In the condition one distinguishes a circumscribed form or abscess, and a diffuse infiltration or phlegmonous inflammation in a true sense. The submucous coat is the principal site of the pathological changes. The stomach wall itself may be six times its normal thickness, and on the cut surface small purulent areas may be seen. Occasionally the abscess points into the stomach cavity, but much more frequently it extends peripherally, and affects the peritoneum. Etiologically one must distinguish between a primary and a secondary variety. In the first variety streptococci present in the food infect small traumatic lesions of the mucous membrane; while in the second variety pyæmic abscesses form in the course of puerperal or other general infections. Gastric ulcer and gastric carcinoma do not in any way predispose to the disease. The clinical symptoms are not typical, but have a close resemblance to those of peritonitis. The prognosis is bad, most cases terminating fatally within from one to twenty days. The only possible treatment is laparotomy and drainage, if a diagnosis is made. M.

Professor E. H. Starling, M.D., F.R.S., gave evidence before the Royal Commission on Vivisection on Wednesday and Thursday last.

Friday last, December 21st, was the sixtieth anniversary of the first operation performed under anæsthetics in Great Britain. The operation was performed at University College Hospital by Robert Liston, F.R.S. ether being the anæsthetic used.

Dr. Gustave Schorstein, whose death was announced on November 24th, has, states the *Lancet*, bequeathed £500 to the Regius Professor of Medicine at the University of Oxford for the Pathological Department of the Medical School, £500 to the London Hospital, and a sum which will probably amount to some £10,000 in trust to the University of Oxford, subject to certain life interests. When these are expired the capital is to be at the disposal of the University for use as that body shall think fit.

NOTICES TO CORRESPONDENTS, &c.

☞ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *Distinctive Signature or Initial*, and to 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 proofs.

CONTRIBUTORS are kindly requested to send their communications if resident in England or the Colonies, to the Editor at the London office; if resident in Ireland, to the Dublin office, in order to save time in reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

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.

SUBSCRIPTIONS.

SUBSCRIPTIONS may commence at any date, but the two volumes each year begin on January 1st and July 1st respectively. Terms per annum, 21s.; post free at home or abroad. Foreign subscriptions must be paid in advance.

SERMO.—Poikilocytosis occasionally is very slightly marked in pernicious anæmia, so that the doubtful appearance of the blood in the case mentioned cannot be held to exclude the condition. It is a valuable point in the diagnosis if the majority of the red corpuscles are larger than normal, especially if there are some very large ones. Microcytes are not now regarded as pathognomonic, as they are found in other diseases. The leucocytes are practically always fewer than normal, and sometimes, especially towards the termination of a case they reach a very low figure.

THE COST OF A STOMACH-ACHE.

A GOOD definition of appendicitis was given by a recent sufferer. He said that it was a modern pain that cost about £200 more than the old-fashioned stomach-ache.

INSURED.—Touts of the kind are far too common, and their impudence is appalling. It is far better to have nothing to do with them. There are recognised and unrecognised ways of doing business, and though an agent's forwardness and impertinence does not necessarily condemn the office as unsound, they certainly fail to cast credit on it. Write to their headquarters.

DR. N. S.—It is possible that your case may be one of tubercle of the lacrymal gland, but very unlikely. The condition has been recorded, but always in connection with tuberculosis elsewhere. Excision of the gland is the proper treatment.

L. D. S.—Yes, foot and mouth disease is communicable to man. It is supposed to be contracted from infected milk or directly from diseased animals. If due to an organism, as is highly probable, it must be able to pass through a porcelain filter, as the filtrate is still capable of reproducing the disease.

R. N. L.—The pancreas may be the seat of congenital syphilis. The arteries show periarteritis and the adventitia is infiltrated with lymphoid cells. It is curious that the islands of Langerhaus do not seem to be primarily involved.

A TOUCHING INCIDENT.

ONE of those dramatic incidents which in a novel would appear incredible, happened at South Kensington Station a night or two ago. You have doubtless heard of the doctor who was killed in trying to board a moving train. This writer has heard the rest of the story from the doctor at St. George's Hospital who received the hopeless "case." When he was picked up on the platform, the officials at once sent for the doctor who was usually summoned to railway accidents at South Kensington. "The doctor has just left home," was the answer. "You must send some one at once," was the call, and the woman at the other end of the telephone, who was a doctor's wife and had been a nurse, said that she would come and do her best. She came to the station, lifted the head of the dying man, and saw the face of her own husband. They say that doctors are callous. But the doctor who saw the tense-faced woman whose husband had been summoned to cure himself, and herself had filled the place, had a tremor of emotion in his voice.—*Daily Chronicle.*

MR. WILTON (Liverpool):—The mortality unfortunately remains about the same, notwithstanding the discovery referred to.

INDIAN MEDICAL SERVICE.

THE next examination of candidates for Commissions in the Indian Medical Service will be held in London on Tuesday, January 29, 1907, and the four following days. Particulars regarding pay, promotion, &c., in the Service, and the necessary forms of application can be obtained from the Military Secretary, India Office, London, S.W. Immediate applications, duly filled up and accompanied by the required certificates, must be made at once. The number of vacancies is eighteen.

DR. S. (Manchester).—We understand the book is now out of print, and as its author has recently died there is no probability of another edition.

DR. L. H.—Such a movement as you suggest has already been set on foot in America. In July this year a committee of the Suffolk (U.S.A.) District Medical Society was appointed as a Milk Commission. The objects were, at the outset, simply to encourage the production of clean milk and to certify milk submitted to them. Excellent regulations were drawn up by them, and the services of the members of the commission were purely honorary

NURSE A. R. G.—Yes, we believe that hospital nurses will count as "workmen" under the new Compensation Act. Although not specifically mentioned, and not domestic servants in the usual sense of the word, we are advised that nurses will come under the provisions of the Act. But it does not come into force till July next, so that the case you cite will have no redress except at common law.

M. A. B.—No organism has yet been assigned a causative rôle in typhus on any undubitable grounds. The best authenticated one is *micrococcus exanthematicus*, described by Lewaschef, and also by Dubief and Brühl. But the whole subject is very obscure.

R. S. O. (Somerset).—We shall be glad if you can communicate with us in London. The article you send is very interesting and we hope to be able to use it if space permits. But we should like to have your address.

Vacancies.

Edinburgh School Board.—Medical Officer. Salary £400 per annum. Applications to G. W. Alexander, Clerk, School Board Offices, Edinburgh.

County Borough of Salford.—Fever Hospital.—Assistant Medical Officer at the Ladywell Sanatorium, Salford. Salary £150 per annum, with apartments and board. Applications to L. C. Evans, Town Clerk, Town Hall, Salford.

King Edward VII. Sanatorium, Midhurst, Sussex.—Pathologist. Salary £250 per annum, with board, lodging, and attendance. Applications to the Hon. Secretary, 19 Devonshire Street, Portland Place, W.

Norfolk County Asylum, Thorpe, Norwich.—Junior Assistant Medical Officer. Salary £150 per annum, all found. Applications to the Medical Superintendent.

Newport Borough Asylum, Caerleon, Mon.—Assistant Medical Officer. Salary £150 per annum, with board, apartments, and attendance. Applications to the Medical Superintendent.

Royal Mineral Water Hospital, Bath.—Resident Medical Officer. Salary £100 per annum, with lodging, board, and laundry. Applications to the Secretary.

South Devon and East Cornwall Hospital, Plymouth.—House Surgeon. Salary £100 per annum, with board, residence, and washing. Applications to P. J. Langdon, Secretary.

Great Northern Central Hospital, Holloway Road, N.—Casualty Officer. Salary £100 per annum. Applications to L. H. Glenton-Kerr, Secretary.

Parish of Paddington.—First Assistant to the Medical Superintendent of the Infirmary and Assistant Medical Officer of the Workhouse. Salary £120 per annum, together with board, lodging, and washing. Applications to the Medical Superintendent at the Infirmary, 285 Harrow Road, W.

Down District Asylum, Downpatrick. — Junior Assistant Medical Officer. Salary £130, rising to £150, per annum, with board, &c. Applications to M. J. Nolan, Resident Medical Superintendent. (See advt.)

Appointments.

CUNNINGHAM, RICHARD G., M.B., Ch.B.Edin., House Physician and Pathologist at Sunderland Infirmary.

CURRIE, JAMES, M.B., M.S.Edin., Certifying Surgeon under the Factory and Workshop Act for the Springhead District of the county of York.

ECKENSTEIN, K. E., M.R.C.S., L.R.C.P., Clinical Assistant to the Chelsea Hospital for Women.

FINLAY, DOUGLAS EDWARD, L.R.C.P.Lond., M.R.C.S., Public Vaccinator to the City of Gloucester.

HOPEWOOD-SMITH, L.R.C.P.Lond., M.R.C.S., L.D.S.Eng., the External Examiner in Dental Subjects for the Third and Final Examinations for the Degrees in Dental Surgery of the University of Birmingham.

HUTCHINSON, J. R., M.B., Ch.B.Vict., D.P.H.Vict., Assistant Medical Officer of Health of the County Borough of Blackburn.

TROTTER, WILFRED B. L., M.D.Lond., F.R.C.S.Eng., Assistant Surgeon to University College Hospital.

WILLCOX, W. H., M.D.Lond., Physician to the Great Northern Central Hospital, Holloway Road, N.

Birth.

GARDINER.—On Dec. 16th, at 1 Queen's Avenue, Muswell Hill, the wife of Douglas Gardiner, M.B., C.M., of a son.

Marriage.

WILKINSON—GOVETT.—On Dec. 19th, at St. Paul's Church, Fisherton, Salisbury, Alfred Hugh Wilkinson, fifth son of the late F. Wilkinson, of Cleveland House, Barnes, to Catherine Elizabeth Govett, youngest daughter of the late Philip William Govett, Staff Surgeon R.N., of Plymouth, and of Mrs. Govett, of Salisbury.

Deaths.

BIRD.—On Dec. 19th, at 1 Trafalgar Square, Fulham Road, Kate widow of Dr. Arthur Hinckes Bird.

CLARK.—On Dec. 15th, at 9 Park Circus, Ayr, Scotland, Elizabeth Mayston, widow of John Andrew Clark, Surgeon, late Bengal Army.

EASTLAKE.—On Dec. 17th, Margaret, wife of the late Henry E. Eastlake, M.D., of Welbeck Street, Cavendish Square, London.

3 GAL 104